

ASSISTED LIVING FACILITY ASSESSMENT MANUAL



**Commonwealth of Virginia
Department of Social Services
Division of Family Services, Adult Services Program
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A NOTE ABOUT THIS REVISION

This manual was prepared in cooperation with staff of the Virginia Departments of Medical Assistance Services (DMAS), Social Services, Aging, Health, Rehabilitative Services, Mental Health, Mental Retardation and Substance Abuse Services, and Corrections as well as public human services agency assessors and other interested parties.

This version replaces the working draft that was issued in February 1996 and the previous manual dated February 1998.

The major changes in this manual from the February 1998 version are:

- Changed “adult care residence” to “assisted living facility.”
- Removed general references to intensive assisted living (IAL); these are collected in a new chapter for those few IAL residents who remain in an ALF.
- Separated “reassessment” and “ongoing targeted case management” into two chapters.
- Added “TIP” boxes throughout to highlight frequently asked questions.
- Added that physicians who have a contract with DMAS may conduct reassessments if they choose to follow their patient on an ongoing basis (formerly they could only perform the initial assessment).
- Clarified duties of assessors, particularly for individuals with a condition of mental illness or mental retardation.
- Clarified definitions of dermal ulcers.
- Clarified when medications are “administered by professional staff” on the Virginia Uniform Assessment Instrument (UAI).
- Noted that the original UAI should always follow the resident.
- Updated DMAS’ policy on forms and where to get them.
- Added community release units of the Department of Corrections as an entity that can complete an initial assessment.
- Stressed when an emergency placement can occur.
- Deleted detailed definitions of ADLs; referred readers to the *User’s Manual: Virginia Uniform Assessment Instrument*.
- Added an index of topics.
- Corrected the mailing address for completed assessment packages.

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PURPOSE OF THIS MANUAL

This manual provides guidance related to the assessment process for assisted living facilities (ALFs) and Medicaid-funded targeted ALF case management. The focus of this manual is ALF residents and applicants who are eligible for or receiving an Auxiliary Grant (AG).

DMAS will not reimburse for assessments of private pay individuals. For information on the assessment of private pay ALF residents, refer to the *User's Manual: Virginia Uniform Assessment Instrument (UAI) for Private Pay Residents of Assisted Living Facilities* which is available from the VDSS Adult Services Program at 804-692-1299.

TIP: This manual is for individuals who are public pay (i.e., Auxiliary Grant) and who are applying to or living in assisted living facilities. See the VDSS website at <http://www.dss.state.va.us/form/index.html> for the manual and form for private pay applicants and residents.

BACKGROUND

The 1993 General Assembly passed significant legislation affecting the ALF industry. To implement this legislation, the State Board of Social Services adopted final regulations concerning the Auxiliary Grant (AG) Program, standards for licensed ALFs, and assessments in ALFs on November 16, 1995. The regulations became effective February 1, 1996. The Department of Medical Assistance Services (DMAS) is responsible for those aspects of the legislation related to the payment of assessments, targeted case management, and assisted living level of care for AG residents of ALFs.

Since July 1, 1994, most publicly funded human service agencies in Virginia, including the local departments of social services, area agencies on aging, centers for independent living, state facility staff of the Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS), and Medicaid nursing home preadmission screening (NHPAS) teams have been using one common assessment, the Uniform Assessment Instrument (UAI), to gather information for the determination of an individual's care needs, for service eligibility, and for planning and monitoring client care needs across agencies and services. The UAI is comprised of a short assessment, designed to be an intake/screening document and a full assessment, designed to be a comprehensive evaluation. The completion of the short UAI (Part A) or full UAI (Part A and Part B) is based on the initial review of the individual's needs and which long-term care service has been requested. See Exhibit 1 in this chapter for the text of the UAI regulation.

TIP: An AG resident may not receive assisted living services concurrently with any other Medicaid-funded in-home or residential support waiver services authorized under Section 1915(c) of the Social Security Act.

Effective February 1, 1996, all ALF applicants, prior to admission, and residents of ALFs must be assessed, at least annually, using the UAI to determine the need for residential or assisted living care, regardless of payment source or length of stay. In addition, all ALF residents must be assessed using the UAI whenever there is a change in the resident's condition that may warrant a change in level of care.

Under Medicaid-funded ongoing, targeted ALF case management services, AG residents will receive an annual reassessment only and/or ongoing targeted case management services. Ongoing Medicaid-funded ALF targeted case management services are also provided to AG residents who have multiple needs across multiple providers when the ALF cannot provide the services but they are available in the community. See Chapter IV for additional information on ongoing, targeted case management services.

DMAS will pay the ALF for services rendered while the individual is determined to be eligible for benefits under the AG program and authorized for assisted living. The assisted living authorization is considered effective as of the date the Long-Term Care Preadmission Screening Authorization (DMAS-96) is signed and dated:

In addition, in order for assisted living payments to be made to a facility, the assisted living authorization must be based on a Uniform Assessment Instrument (UAI) that complies with the requirements of *Code of Virginia*, § 63.2-1804.

AUXILIARY GRANT PROGRAM

The Auxiliary Grant (AG) Program is a state and locally funded assistance program to supplement the income of a recipient of Supplemental Security Income (SSI) and certain other aged, blind, or disabled individuals residing in a licensed ALF. This is assistance available from local departments of social services to ensure that recipients are able to maintain a standard of living that meets a basic level of need. Before an individual can receive assistance from the AG program, the local department of social services must determine eligibility for the program where the individual has residence. Residence for AG eligibility is determined by the city or county within the state where the person last lived outside of an institution or adult family care home. Any records/statements can be used to determine place of residence. If residency cannot be determined, or if the individual is from out-of-state, residency is where the individual is living at the time of application. If the individual is entering the ALF from a state institution, the application is to be filed in the locality where the individual resided before he or she entered the state institution.

Entitlement to assistance for an individual meeting all eligibility criteria begins the month the application for the AG program is received by a local department of social services. If an individual does not meet all eligibility criteria at the time of application, but meets all criteria when the application is processed, entitlement begins the month all criteria are met.

All applicants for an AG must have an assessment completed before AG payment can begin. Verification of the initial assessment will be a completed DMAS-96, Long-Term Care Preadmission Screening Authorization (see Chapter II), sent to the appropriate local department of social services eligibility worker by the assessor. At the time of the resident's annual reassessment, the assessor completes the ALF Eligibility Communication Document (Appendix C). This form tells the eligibility worker that the resident continues to meet the criteria for continued ALF placement so that AG eligibility can be redetermined.

An individual's Medicaid number can usually be used to determine which local department of social services is responsible for determining an individual's eligibility for an AG. The first three numbers of the Medicaid number correspond to the city/county code (FIPS code) of the local department of social services that is responsible for the payment of the AG. The FIPS codes are found in Exhibit 2 of this chapter. The assessor is advised to use any other documentation that may be available to assist in determining the appropriate local department of social services.

To be eligible for an AG in Virginia, an individual must meet all of the following:

- Be 65 or over or be blind or be disabled.
- Reside in a licensed ALF or adult family care home.
- Be a citizen of the United States or an alien who meets specified criteria.
- Have a non-exempted (countable) income less than the total of the AG rate approved for the ALF plus the personal needs allowance.
- Have non-exempted resources less than \$2,000 for one person or \$3,000 for a couple (as of 1/98).
- Have been assessed and determined to be in need of care in an ALF or adult family care home.

The Auxiliary Grant provides for the following services:

Room and Board

- Provision of a furnished room in a facility that meets applicable building and fire safety codes.
- Housekeeping services based on the needs of the resident.
- Meals and snacks, including extra portions and special diets.
- Clean bed linens and towels as needed and at least once a week.

Maintenance and Care

- Medication administration, including insulin injections.
- Provision of generic personal toiletries including soap and toilet paper.
- Minimal assistance with personal hygiene including bathing, dressing, oral hygiene, hair grooming and shampooing, care of clothing, shaving, care of toenails and fingernails, arranging for haircuts as needed, care of needs associated with menstruation or occasional bladder or bowel incontinence.
- Minimal assistance with care of personal possessions; care of personal funds if requested by the recipient and residence policy allows it; use of telephone; arranging transportation; obtaining necessary personal items and clothing; making and keeping appointments; correspondence; securing health care and transportation when needed

for medical treatment; providing social and recreational activities as required by licensing regulations; and general supervision for safety.

DESCRIPTION OF AN ASSISTED LIVING FACILITY

Assisted living facilities (ALFs) are licensed by the Virginia Department of Social Services (VDSS), Division of Licensing Programs, to provide maintenance or care to four or more adults. ALF placement is appropriate when the adult is assessed to need assistance with activities of daily living (ADLs), instrumental activities of daily living (IADLs), administration of medication and/or supervision due to behavioral problems, but does not require the level of care provided in a nursing facility. A list of licensed ALFs can be obtained by contacting the VDSS Licensing Regional Office at 804-692-1776. Contact information is found in Appendix E.

TIP: ALFs are licensed by VDSS and provide care and maintenance to four or more adults.

ALFs are licensed to provide 1) residential living only or 2) residential level and assisted living level of care. DMAS reimbursement for assisted living began August 1, 1996. ALFs must be licensed by VDSS for assisted living before they can enroll with DMAS as an assisted living provider. Payment for assisted living services are effective from the date of authorization on the Long-Term Care Preadmission Screening Authorization (DMAS-96).

Once an ALF has been licensed by VDSS for assisted living, the ALF can enroll as a Medicaid provider to receive payment for assisted living services on behalf of its AG residents. Initially, the ALF will submit an admission package (as described in Chapter II) to receive approval to bill for assisted living services. DMAS will reimburse \$3 per day up to \$90 a month for assisted living services. Payment will be made directly to assisted living facilities through the submission of a HCFA-1500 invoice to DMAS. These payments are an add-on payment to the base AG payment that the ALF receives directly from the resident. Please note that AG payments are made by VDSS directly to the resident, not the ALF.

A NOTE ON INTENSIVE ASSISTED LIVING CARE

Prior to March 17, 2000, there were two levels of assisted living care, for payment purposes in ALFs (regular assisted living and intensive assisted living), which were available to individuals who require assistance in activities of daily living and instrumental activities of daily living, which are above the room, board, and supervision provided by the ALF and as reimbursed by the AG program. In March 2000, the Health Care Financing Administration (now the Centers for Medicare and Medicaid) did not renew Virginia's Intensive Assisted Living Waiver. On and after March 17, 2000, the IAL Waiver is no longer available as a Medicaid-funded alternative to nursing facility placement for new

TIP: Effective March 17, 2000, no new applicants can be assessed to be in the Intensive Assisted Living Waiver. There are now two levels of care in ALFs—residential living care and assisted living care.

applicants. There are now only two levels of care: residential care and assisted living. Please see Chapter VI for information on the Intensive Assisted Living Program.

DEFINITION OF ASSESSMENT

The ALF assessment using the Virginia Uniform Assessment Instrument (UAI) is a standardized approach using common definitions to gather sufficient information on applicants to and residents of ALFs to determine their care needs, and, for AG recipients, to determine their need for residential care. Assessment is the prior-authorizing mechanism for public reimbursement for ALF services.

Assessment of ALF applicants and residents is a process to:

- Evaluate the medical, nursing, developmental, psychological, and social needs of each individual seeking ALF admission and continued placement;
- Analyze what specific services the individual needs; and
- Determine the level of care required by the individual by applying the criteria for ALF care. (See Appendix A for ALF level of care criteria.)

The assessment of the availability of ALF services depends upon:

- Whether an ALF, licensed to provide the level of care to meet the needs of the individual, exists in the community;
- Whether financial eligibility can be established; and
- Whether the ALF states/demonstrates that it can meet the individual's needs.

POPULATION TO BE ASSESSED

Except in the event of a documented emergency (see Chapter III), all individuals must be assessed to determine the necessity for ALF placement **prior to** the ALF placement. Please note that this manual describes procedures for the assessment of AG recipients and applicants. Public human services agency assessors are not required to assess private pay individuals, but may when requested to do so. If they choose to assess private pay individuals, the public human services agency assessor may not charge more than the public pay reimbursement rates for conducting the assessment.

TIP: ALL residents of and applicants to ALFs, regardless of payment status or anticipated length of stay, must be assessed using the UAI to determine the need for residential or assisted living care prior to admission.

THE VIRGINIA UNIFORM ASSESSMENT INSTRUMENT (UAI)

The Virginia Uniform Assessment Instrument (UAI) is required to be used by all public human services agencies that provide long-term care services. The UAI provides the framework for determining an individual's care needs. It contains measurable and common

definitions for rating how individuals function in daily life activities. For public pay residents, only the short assessment (first four pages) of the UAI is required plus an assessment of behavior and medication administration. If, upon completion, it is determined that the individual is dependent in two activities of daily living or dependent in behavior, then the full assessment (12 pages of the UAI) must be completed.

ASSESSORS FOR PUBLIC PAY INDIVIDUALS

For public pay individuals, assessors include the following Virginia public agencies:

- **Local departments of social services:** There are 121 local departments of social services (LDSS) across the state that serve as the service entry point for customers. Local agency staffs are responsible for determining eligibility for participation in assistance programs. Staffs are authorized to make payments to customers and vendors for services and provide direct services and family-focused case management to customers. Adult services targets persons over age 60 and persons with disabilities and over age 18 and their families when appropriate. Goals include maximization of self-sufficiency, prevention of abuse, neglect, and exploitation, a reduction and delay in premature or unnecessary institutionalizations, and assistance when such placement is appropriate. Home-based services offered by LDSS include companion, homemaker, and chore services; other services that may be offered include adult day care and adult foster care. LDSS also participate on the Nursing Home Preadmission Screening (NHPAS) Team with local health departments and can authorize Medicaid-funded nursing facility or community-based care services. Staff of the central and regional office Division of Licensing Programs license ALFs, monitor compliance with licensing standards, and ensure that all ALF residents are assessed prior to admission, at least annually, and as needed.
- **Area agencies on aging.** The mission of the area agencies on aging (AAAs) is to develop or enhance comprehensive and coordinated community-based systems of services for the elderly in their designated planning and service areas. Such systems are designed to assist older persons in leading independent, meaningful, and dignified lives in their own homes and communities as long as possible. Each AAA serves a specific geographic area known as the planning and service area (PSA). The 25 AAAs serve all jurisdictions in the state. AAAs provide services directly or through contracts with other community service providers.
- **Centers for independent living.** Centers for independent living (CILs) provide peer counseling, information and referral, independent living skills training, and advocacy to people with all types of disabilities. These are non-profit centers in Virginia operated primarily by people with disabilities. The Department of Rehabilitative Services at the Woodrow Wilson Rehabilitation Center operates another independent living program.

- **Community services boards.** Community services boards (CSBs) deliver mental health, mental retardation, and substance abuse services. CSBs provide these services in the most accessible, responsible, and appropriate, yet least restrictive setting possible. CSBs provide some services in all 136 cities and counties in Virginia. Boards function not only as service providers, but also as client advocates, community educators and organizers, program developers and planners, and advisors to their local governments, serving as the locus of fiscal and programmatic accountability.
- **Local departments of health.** There are 201 local health departments, including every city and county in the Commonwealth. They are responsible for local health initiatives that vary according to the needs of the community. Some local health departments sponsor home health programs. Each local health department belongs to a district health department. Local health departments also participate on the NHPAS Team with local departments of social services and can authorize Medicaid-funded nursing facility or community-based care services.
- **An independent physician contracting with DMAS.** An independent physician is a physician chosen by the ALF resident and who has no financial interest in the ALF, directly or indirectly, as an owner, officer, or employee or as an independent contractor with the residence.
- **State facilities operated by the Department of Mental Health, Mental Retardation and Substance Abuse Services.** There are 15 state facilities in the Commonwealth that provide inpatient services for persons with mental illness or mental retardation.
- **Acute care hospitals.** There are 130 hospitals in the Commonwealth, many of which contract with DMAS to perform NHPAS or to complete the UAI for a home- and community-based waiver program. Veterans Administration hospitals could participate if their physicians enroll as a Medicaid provider for assessments. These entities are limited to the initial assessments. Qualified emergency room staff could complete the assessment and authorization for ALF services if their hospital has a contract with DMAS to perform NHPAS.
- **Department of Corrections, Community Release Units or the Department's designee.** Staff trained to complete the UAI may complete the initial assessment only for inmates who may be appropriate for ALF services and have reached their appropriate release status. The authority to conduct an initial assessment for ALF

TIP: Veterans Administration hospitals can perform initial assessments if their physicians enroll as a Medicaid provider for assessments.

services does not extend to those inmates who might be appropriate for nursing facility placement. The local departments of social services and health in the areas where the inmates are residing prior to discharge must complete those preadmission screenings.

All of the above assessors may conduct initial assessments as well as annual reassessments with the exception of:

- State facilities operated by the Department of Mental Health, Mental Retardation and Substance Abuse Services
- Acute care hospitals
- Department of Corrections Community Release Units or the Department's designee.

These three entities may **only** complete the initial assessment and must send a copy of the UAI, DMAS-96, and reassessment date to the Adult Services Supervisor of the LDSS where the individual will reside.

RESPONSIBILITIES OF DMAS, ASSESSORS, AND ALF STAFF

Department of Medical Assistance Services Responsibilities

The responsibilities of the Department of Medical Assistance Services are:

- Payment for assessments and targeted case management.
- Reimbursement to ALF providers for the add-on payment for assisted living
- Enrollment of providers (assessors and ALFs).
- Conducting utilization review of assisted living services to assure that authorized services were appropriately delivered.

Assessor Responsibilities

The following responsibilities apply to *any* public human services agency assessor, as listed previously, who completes an initial assessment for an individual.

- Determining if the individual to be assessed is already receiving an AG or has made application for the AG.
- Completing the assessment process within two weeks of the referral (including UAI, consent form, and determining if the individual is appropriate for an ALF and has no prohibited conditions).
- Determining appropriate level of care and authorizing services (completing the DMAS-96 and preparing the authorization letter to the individual).

- Contacting the ALF of choice and determining if the ALF's licensure matches the individual's authorization and if the ALF can meet the individual's needs.
- Assisting the individual directly, which may include transportation.
- Submitting all paperwork to all entities as directed.
- Referring the individual for a psychiatric or psychological evaluation if needed.
- Planning for the required annual reassessment; making referrals to an alternate assessor if needed.

Additional Responsibilities of the Department of Social Services

In addition to the above responsibilities of agency assessors, the responsibilities of the Department of Social Services in the assessment of ALF residents include:

- Ensuring that all residents are assessed as required.
- Monitoring compliance with Division of Licensing Programs' standards.
- Performing the licensing of ALFs.

ALF Staff Responsibilities

The ALF staff is responsible for ensuring that an assessment is conducted prior to the individual's admission to determine if he or she meets ALF criteria. ALF staff must coordinate with the assessor to ensure that assessments are completed as required. Except in the event of a documented emergency (see Chapter III), all individuals must be assessed to determine necessity for ALF placement **prior to** the placement. ALF staff must keep all assessments and related documentation in the resident's record. ALF staff must comply with the standards and regulations of the VDSS Division of Licensing Programs as well as with all standards and regulations of DMAS if the facility chooses to participate and receive Medicaid reimbursement.

ALF staff must know the criteria for the levels of care in an ALF and are responsible for arranging for the discharge of the resident whenever a resident does not meet, either upon admission or at any later time, the criteria for level of care for which the ALF is licensed. Discharge is the process that ends the stay in an ALF. ALF staff must plan for post-discharge services when the resident is returned to a home-based placement, a nursing facility, another ALF, or facility operated by DMHMRSAS. ALF staff must notify the LDSS financial eligibility worker in the jurisdiction responsible for authorizing the AG of the date of discharge and also notify the case manager, if applicable. The current UAI should follow the resident.

The VDSS Division of Licensing Programs requires a physical examination be completed for new admissions to the ALF. ALF staff, and not the assessor, is responsible to ensure that the examination is completed. The Division of Licensing Programs has made available a model

form for the physical examination. Other forms may be used if they contain the same information as the model form.

COORDINATION OF ASSESSMENTS

When there is no other qualified assessor willing or able, the local departments of social services must provide the service. Any entity above is authorized to perform initial ALF assessments. All assessors within a locality should coordinate assessment and reassessment responsibilities for the locality so that the assessment and reassessment burden does not fall solely on one agency.

If ALF residents have been assessed with the UAI by any public agency and the assessment is less than 12 months old, it is not necessary to complete a new UAI. Instead, the assessor making the placement should review and update the current UAI as needed by striking through and updating the appropriate elements, complete the Medicaid authorization process (see Chapter II), and send to all necessary parties for notification and payment (also Chapter II). For new admissions, previously completed UAIs are acceptable if completed within 90 days prior to admission, and there has been no significant change in the applicant's physical and/or functional condition. The transfer process may not include a new assessment unless there is a change in level of care. In routine transfers from one ALF to another where there is no change in level of care, the sending and receiving ALFs must ensure that all requirements are followed. The current UAI should follow the resident.

TIP: For new admissions, previously completed UAIs are acceptable up to 90 days prior to admission.

State regulation (22 VAC 40-745-10 et seq.) authorizes public human service agencies and other qualified assessors to complete assessments for AG recipients and applicants needing ALF placement. Assessors may be reimbursed for assessments provided that they have a contract for those activities with DMAS. Certain providers may be more appropriate to complete assessments than others. For example, staff of a community services board may more appropriately serve a resident who is mentally ill or mentally retarded.

SUBCONTRACTORS

If a subcontractor is used by an authorized agency to complete assessments, the contracting agency is responsible to monitor the subcontractor's performance. The DMAS provider agreement states that, "The provider agrees, at all times, to retain full responsibility for any and all performance under this agreement, whether performed by the provider or others under contract to the provider." The contracting agency will be responsible for the quality, accuracy, and timeliness of any assessment completed by a subcontractor. In the case of a subcontractor, the authorized assessment agency requests the reimbursement for the assessment from DMAS. DMAS reimburses the authorized assessment agency that, in turn, reimburses the subcontractor.

ALFs OPERATED BY A COMMUNITY SERVICES BOARD

Some community services boards (CSBs) also operate an ALF. In this case, the CSB employee can complete the UAI for residents of the agency-operated ALF. In order to be reimbursed for a public pay assessment, the assessor may be an employee of the CSB, but not of the ALF. The distinction is whether the staff is considered direct service staff. Direct service staff or employees of the ALF cannot perform either assessment or targeted ALF case management services to the residents. If the ALF staff is also the resident's case manager, case management will be a part of the staff's usual responsibilities and will not be reimbursed separately by DMAS. If an agency staff person is placed in a facility to facilitate case management activities, such staff could complete the assessment and perform targeted case management services and be reimbursed by DMAS for these activities.

FREEDOM OF CHOICE

For public pay individuals, the assessor or case manager must offer the individual the choice of service provider(s), including case managers and ALFs. When ongoing Medicaid-funded targeted ALF case management is needed, these choices must be documented on the Plan of Care (see Appendix C). The individual's choice of providers is a federal, as well as professional and ethical, requirement.

RECORDS RETENTION AND DOCUMENTATION REQUIREMENTS

All assessment forms and Medicaid authorization forms (e.g., the DMAS-96) must be retained for a period of not less than five years from the date of the assessment and/or implementation of case management services. Assessments and related documentation must be legible and maintained in accordance with accepted professional standards and practices. All records, including the UAI as well as any computerized records and forms, must be completely signed with name and professional title of author and completely dated with month, day, and year.

CASE MANAGEMENT

Case management is a system under which the responsibility for locating, coordinating, and monitoring services rests with a designated person or organization. Medicaid-funded ALF case management includes the annual reassessment only or ongoing targeted case management. It is believed that most of the AG residents of ALFs will only need the required annual reassessment and not ongoing targeted case management services. See Chapter V for additional information on Medicaid-funded ALF targeted case management services.

**EXHIBIT 1. SELECTIONS FROM THE *CODE OF VIRGINIA* RELATING TO THE
UNIFORM ASSESSMENT INSTRUMENT**

§ 63.2-1804. Uniform Assessment Instrument. A uniform assessment instrument setting forth a resident's care needs shall be completed for all residents upon admission and at subsequent intervals as determined by State Board regulation. No uniform assessment instrument shall be required to be completed upon admission if a uniform assessment instrument was completed by a case manager or other qualified assessor within ninety days prior to such admission to the assisted living facility unless there has been a change in the resident's condition within that time which would affect the admission. Uniform assessment instruments shall not be required to be completed more often than once every twelve months on individuals residing in assisted living facility unless there has been a change in the resident's condition within that time which would affect the admission. Uniform assessment instruments shall not be required to be completed more often than once every twelve months on individuals residing in assisted living facilities except uniform assessment instruments shall be completed whenever there is a change in the resident's condition that appears to warrant a change in the resident's approved level of care. At the request of the assisted living facility, the resident's representative, the resident's physician, the Department of Social Services or the local department of social services, an independent assessment, using the uniform assessment instrument shall be completed to determine whether a resident's care needs are being met in the current placement. The resident's case manager, or other qualified assessor shall complete the uniform assessment instrument for public pay residents or, upon request by private pay resident, for private pay residents. Unless a private pay resident requests the uniform assessment instrument be completed by a case manager or other qualified assessor, qualified staff of the assisted living facility or an independent private physician may complete the uniform assessment instrument for private pay residents; however, for private pay residents, social and financial information which is not relevant because of the resident's payment status shall not be required. The cost of administering the uniform assessment instrument pursuant to this section shall be borne by the entity designated pursuant to state board regulations. Upon receiving the uniform assessment instrument prior to admission of a resident, the assisted living facility administrator shall provide written assurance that the residence had the appropriate license to meet the care needs of the resident at the time of admission.

§ 63.2-800. In order to receive an auxiliary grant while residing in an ALF, an individual shall have been evaluated by a case manager or other qualified assessor as defined in § 63.2-100 to determine his need for residential care. . . For purposes of this section, case manager means an employee of a human service agency who is qualified and designated to develop and coordinate plans of care.

§ 63.2-800. Definitions. "Qualified assessor" means an entity contracting with the Department of Medical Assistance Services to perform nursing facility preadmission screening or to complete the uniform assessment instrument for a home and community-based care waiver program, including an independent physician contracting with the Department of Medical Assistance Services to complete the uniform assessment instrument for residents of assisted living facilities, or any hospital which has contracted with the Department of Medical Assistance to perform nursing facility preadmission screenings.

EXHIBIT 2. CITY/COUNTY (FIPS) CODES

Counties

001 Accomack
003 Albemarle
005 Alleghany
007 Amelia
009 Amherst
011 Appomattox
013 Arlington
015 Augusta
017 Bath
019 Bedford
021 Bland
023 Botetourt
025 Brunswick
027 Buchanan
029 Buckingham
031 Campbell
033 Caroline
036 Charles City
037 Charlotte
041 Chesterfield
043 Clarke
045 Craig
047 Culpeper
049 Cumberland
051 Dickenson
053 Dinwiddie
057 Essex
059 Fairfax
061 Fauquier
063 Floyd
065 Fluvanna
067 Franklin
069 Frederick
071 Giles
073 Gloucester
075 Goochland
077 Grayson
079 Greene
081 Greensville
083 Halifax
085 Hanover
087 Henrico
089 Henry
091 Highland
093 Isle of Wight
095 James City
097 King & Queen
099 King George

101 King William
103 Lancaster
105 Lee
107 Loudoun
109 Louisa
111 Lunenburg
113 Madison
115 Mathews
117 Mecklenburg
119 Middlesex
121 Montgomery
125 Nelson
127 New Kent
131 Northampton
133 Northumberland
135 Nottoway
137 Orange
139 Page
141 Patrick
143 Pittsylvania
145 Powhatan
147 Prince Edward
149 Prince George
153 Prince William
157 Rappahannock
159 Richmond County
161 Roanoke County
163 Rockbridge
165 Rockingham
167 Russell
169 Scott
171 Shenandoah
173 Smyth
175 Southampton
177 Spotsylvania
179 Stafford
181 Surry
183 Sussex
185 Tazewell
187 Warren
191 Washington
193 Westmoreland
195 Wise
197 Wythe
199 York

Cities

510 Alexandria
515 Bedford
520 Bristol
530 Buena Vista
540 Charlottesville
550 Chesapeake
560 Clifton Forge
570 Colonial Heights
580 Covington
590 Danville
595 Emporia
600 Fairfax City
610 Falls Church
620 Franklin
630 Fredericksburg
640 Galax
650 Hampton
660 Harrisonburg
670 Hopewell
678 Lexington
680 Lynchburg
683 Manassas
685 Manassas Park
690 Martinsville
700 Newport News
710 Norfolk
720 Norton
730 Petersburg
740 Portsmouth
750 Radford
760 Richmond City
770 Roanoke City
780 South Boston
790 Staunton
800 Suffolk
810 Virginia Beach
820 Waynesboro
830 Williamsburg
840 Winchester

CHAPTER II: ASSISTED LIVING FACILITY ASSESSMENT AND AUTHORIZATION

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REQUEST FOR ASSESSMENT

An assessment to determine the need for assisted living facility (ALF) care must be completed for *any* Auxiliary Grant (AG) individual applying for ALF admission. The assessment must be completed *prior to* the individual's admission to the ALF.

The adult seeking placement, a family member, the physician, a community health services or social services professional, or any other concerned individual in the community can initiate a request for assessment. If the individual is in the community at the time of referral, a local assessor will conduct the initial evaluation. See Chapter I for a description of who is authorized to complete the assessment.

TIP: DMAS will reimburse authorized assessors only for the initial assessment, annual reassessment, change in level of care, and ongoing targeted ALF case management of AG recipients or applicants.

RESPONSE TO ASSESSMENT REQUEST

When a referral is made to a local assessor to conduct an assessment, a contact (via telephone) must be made as soon as possible after receipt of the referral. The assessment process should be completed as soon as possible. All assessments must be completed, a decision letter sent to the individual assessed, and any referrals for services made within two weeks of the receipt of the referral. If the assessor contacted cannot meet this response time, the assessor should refer this assessment to another assessor. New applicants for AGs must be assessed within the 45-day processing time for the AG application. If the assessment is not completed within 45 days after the AG application is submitted, the eligibility worker may extend the pending status of the AG case an additional 15 days. If action to approve or deny cannot be taken within 45 days, action affirming the pending status of the application must be taken and a notice sent to the applicant explaining the reason action was not taken.

TIP: The initial assessment process and the process for determination of eligibility for an AG should be pursued simultaneously.

If an individual is not currently receiving an AG or has not made application for an AG subsequent to ALF admission, the ALF assessment process is completed by an individual authorized to complete private pay UAI's.

DETERMINATION OF ELIGIBILITY FOR AN AUXILIARY GRANT

The assessor must first determine if the individual to be assessed is already receiving an AG or has applied for an AG. If the individual is not already eligible, the assessor must advise the individual and/or the individual's family to contact the local department of social services (LDSS) to determine eligibility. The LDSS eligibility worker in the locality in which the individual resided prior to admission to the ALF must be informed that ALF placement is being sought.

The eligibility determination process must begin early so that the assigned eligibility worker will have sufficient time to complete the eligibility determination. The assessor should instruct the individual and family to prepare for the eligibility process by taking proof of

income, copies of bank statements, life insurance policies, savings certificates, stocks, bonds, etc., to the eligibility appointment.

At the time the request is made, the assessor must inform the individual or family that:

1. The authorization for public payment for ALF services does not mean that the individual will definitely become financially Medicaid-eligible or receive an AG;
2. Financial eligibility must be determined by an eligibility worker from the LDSS;
3. Medicaid cannot reimburse for services unless the individual has been determined to be financially eligible; and
4. The individual may have a responsibility for partial payment for public-funded services, if authorized.

The assessor shall conduct a preliminary screening of an individual's financial status and estimate whether the individual would likely be eligible for an AG. However, an assessor would still be reimbursed for an assessment of an individual who is in good faith thought to be AG eligible, but later determined to be not financially eligible for an AG.

CONSENT TO EXCHANGE INFORMATION

Prior to collecting any information as a part of the assessment process, the assessor must advise individuals of the purpose for seeking this information and the consequences of failure to provide information, and must obtain a Consent to Exchange Information Form (see Appendix E). Any legally competent individual who refuses to sign the consent form must be advised that the assessor may not proceed with the assessment process without a signed consent form. Any individual who is not legally competent to sign the consent form must have a legally authorized representative sign the consent form prior to completion of the assessment process. The consent form allows the assessor to share information obtained through the assessment with ALFs or public human service agencies. These entities are required by law to maintain the individual's confidentiality.

For the "Consent to Exchange Information," responsible persons are: parents (for minor children), legal guardian, and persons who have power of attorney. DMAS will accept the consent of any primary caregiver as the "Responsible Person" for Medicaid programs. Agencies should refer to their own agency policies about releasing information.

ALFs must also be aware of rules governing electronic transactions involving use of an individual's health records according to the Health Insurance Portability and Accountability Act (HIPAA). HIPAA includes standards relating to health information being sent over digital networks.

OUT-OF-STATE APPLICANTS TO ASSISTED LIVING FACILITY CARE

All assessments completed for public pay residents must be completed during an on-site visit, such as to the facility or the individual's home. The only exception may be the screening assessment that may be completed by telephone by the Virginia authorized assessor for out-

of-state applicants. However, the Virginia assessor having jurisdiction must verify this assessment information within 7 days of the adult's admission to a Virginia ALF. All required paperwork must be completed.

COMPLETION OF THE VIRGINIA UNIFORM ASSESSMENT INSTRUMENT (UAI)

General Information

The UAI is comprised of a short assessment and a full assessment. The short assessment (Part A or pages 1-4) plus questions on behavior and medication management is designed to briefly assess the individual's need for services and to determine if a full assessment (Parts A+B or entire UAI) is needed. Based on a prior study of ALF residents, it was determined that about 65 percent of the assessments will be short assessments for residential living residents, and 35 percent of assessments will be full assessments for assisted living residents. The UAI is designed to be a standardized and reproducible assessment of individuals seeking or receiving long-term care services and is used by public human services agencies statewide for a variety of purposes.

The assessment focuses on the functional dependencies and other needs of the individual with emphasis on assessing the total individual as **he or she functions in his or her usual environment**. The assessor must consult with other appropriate human services professionals as needed to complete the assessment. The information is documented on the UAI. The UAI is shown in Appendix C of this manual.

A manual entitled *User's Manual: Virginia Uniform Assessment Instrument* (available from DMAS) provides thorough instructions regarding completion of the assessment and must be utilized in the completion of the UAI. It is very important that a correct assessment of the individual's functional status and other needs be recorded on the UAI, since these areas form the basis for a determination of whether the individual meets the assisted living facility level of care criteria. The assessor must note the individual's degree of independence or dependence in various areas of functioning.

TIP: The assessor must base the assessment on what the individual is capable of doing, regardless of whether the ALF routinely offers a certain service (e.g., housekeeping, laundry). Refer to definitions in the User's Manual: Virginia Uniform Assessment Instrument for assistance.

It is important to note that the process used to assess dependency considers how the person is currently functioning (e.g., is the individual actually receiving assistance to perform an activity of daily living) and whether the way the person is currently functioning demonstrates a need for assistance to perform the activity (i.e., the individual does not receive assistance to bathe but is unable to adequately complete his or her bath and as a consequence has recurrent body rashes). If the person currently receives the assistance of another person to perform the activity or if the person demonstrates a need for the assistance of another person to complete the activity, the person is deemed dependent in that activity. The need of the individual for prompting or supervision in order to complete an activity qualifies as a dependency in that activity.

The individual's care needs must be considered and clearly documented on the UAI to support the outcome of the assessment (i.e., qualifying or not qualifying for placement in an

ALF). This determination is based on a view of the individual's total needs, both functional and medical. Information gathered on the UAI will allow the assessor to determine whether the individual meets the level of care criteria for ALF placement. An individual must meet these criteria to be considered for public-funded ALF placement.

All assessments completed for public pay residents must be completed during an on-site visit, such as to the facility or the individual's home. The only exception may be the screening assessment that may be completed by telephone for out-of-state applicants. However, this assessment information must be verified within 7 days of admission to a Virginia ALF. Collaboration also may be needed by telephone over long distances.

TIP: Level I and II assessments for conditions of MI and MR are not required for ALF admissions. These are federal requirements for nursing facility admissions only.

When to Complete a UAI

1. The UAI must be completed within 90 days prior to the date of admission to the ALF. If there has been a change in the individual's condition since the completion of the UAI that would affect the admission to an ALF, the UAI must be completed or updated. If a resident moves from one ALF to another ALF, a new UAI is not required unless there has been a change in the resident's condition or the assessment is more than twelve months old. A UAI that has been completed for other long-term care services can be used with the same time limitations previously given. The assessor should review and update the UAI as needed and complete the authorization process necessary to receive DMAS payment.
2. An assessment using either the short-form or complete UAI, as appropriate, must be completed at least once every 12 months on all ALF residents. The annual reassessment is based upon the date of the last assessment (i.e., original assessment, annual reassessment, or assessment for change in level of care) and does not need to be performed in the same month as the financial eligibility redetermination. The financial eligibility worker must have documentation in the eligibility record that there is a current assessment on file (a current assessment is one that is not older than 12 months). If a resident is already receiving case management services under a DMAS waiver program, the case manager assigned under the waiver will complete the annual assessments as part of the waiver service.
3. The UAI must be completed or updated as needed whenever there is a significant change in the resident's condition that is expected to last more than 30 days or appears to warrant a change in the resident's approved level of care.

Completing the Short Form of the UAI

For public pay individuals, the short form (first four pages of the UAI) plus an assessment of the individual's medication management ("How do you take your medicine?" question on page 5 of the UAI) and behavior ("Behavior Pattern" section on page 8 of the UAI) must be completed. (Note: DMAS will only reimburse the assessor at the short-form rate if that is all that is needed even if the full assessment is completed. DMAS will monitor the completion of assessments to ensure that reimbursements are appropriate.)

Assessors will complete only the short assessment when the individual is:

- Rated dependent in only one of seven activities of daily living (ADLs); OR
- Rated dependent in one or more of four selected instrumental activities of daily living (IADLs); OR
- Rated dependent in medication administration.

*TIP: The original
UAI should always
follow the resident.*

In determining whether a person is dependent in medication administration (i.e., “administered by professional staff”), this choice should be made when a professional staff person is necessary to **assess** the individual and **evaluate** the efficacy of the medications and treatment. The medication management course for medication aides and subsequent certification does not qualify an individual to be considered as “administered by professional staff.”

For short assessments completed for AG recipients, the first four pages plus questions on medication administration on page 5 and behavior pattern on page 8 must be completed. An add-on page which includes only these two variables or page 2 of the private pay UAI may be used. A copy of the add-on page is shown in Appendix C. A grid for the combination variable behavior pattern and orientation is shown in Exhibit 5.

Completing the Full Assessment

If, upon completing the short assessment, it is noted that the individual is rated dependent in two or more ADLs or is rated dependent in behavior pattern, then a full assessment should be completed. DMAS will monitor assessments to ensure that the appropriate version (i.e., short vs. full) is completed.

PROHIBITED CONDITIONS

Assessors must also determine that individuals do not have any of the prohibited conditions listed below before authorizing placement in an ALF. If any of these conditions are present, the assessor must document that they are present on the UAI, and the AG recipient or applicant is not eligible for ALF placement. If appropriate, contact a health care or mental health care professional for assistance.

State law prohibits admission or retention of individuals in an ALF when they have any of the following conditions or care needs (bold text is used to indicate language from the law):

1. **Ventilator dependency:** A situation where a ventilator is used to expand and contract the lungs when a person is unable to spontaneously breathe on his or her own. Some individuals require the ventilator for all of their respirations, while others require it in the event that they are unable to breathe on their own.
2. **Dermal ulcers stage III and IV except those stage III ulcers which are determined by an independent physician to be healing** and care is provided by a licensed health care professional under a physician's treatment plan: Dermal ulcers include pressure ulcers (e.g., bed sores, decubitus ulcers, pressure sore) which may be caused by pressure resulting in damage of underlying tissues and stasis ulcers (also called venous ulcer or ulcer related to peripheral vascular disease) which are open

lesions, usually in the lower extremities, caused by a decreased blood flow from chronic venous insufficiency. The prohibition is based on the size, depth, and condition of the wound regardless of the cause. The following is a summary of dermal ulcer stages:

Stage I: A persistent area of skin redness, without a break in the skin, that does not disappear when pressure is relieved.

Stage II: A partial thickness loss of skin layers that present clinically as an abrasion, blister, or shallow crater.

Stage III: A full thickness of skin lost, exposing the subcutaneous tissues; presents as a deep crater with or without undermining adjacent tissue. The wound extends through all layers of the skin and is a primary site for a serious infection to occur. The goals and treatments are to alleviate pressure and covering and protecting the wound as well as an emphasis on nutrition and hydration. Medical care is necessary to promote healing and to treat and prevent infection. This type of wound progresses very rapidly if left unattended.

Stage IV: A full thickness of skin and subcutaneous tissue is lost, exposing muscle or bone. This wound extends through the skin and involves underlying muscle, tendons, and bone. The diameter of the wound is not as important as the depth. This is very serious and can produce a life-threatening infection, especially if not aggressively treated. All of the goals of protecting, cleaning, and alleviation of pressure on the area still apply. Nutrition and hydration is now critical. Without adequate nutrition, this wound will not heal. This wound requires medical care by someone skilled in wound care. Surgical removal of the necrotic or decayed tissue is often used on wounds of larger diameter.

3. **Intravenous therapy or injection directly into the vein except for intermittent intravenous therapy managed by a health care professional licensed in Virginia.** If the course of treatment extends beyond a two-week period, an evaluation by the licensed health care professional is required every two weeks.

Intravenous (IV) therapy means that a fluid or drug is administered directly into the vein. Examples may include the infusion of fluids for hydration, antibiotics, chemotherapy, narcotics for pain, and total parenteral nutrition (TPN).

Intermittent intravenous therapy may be provided for a limited period of time on a daily or periodic basis by a licensed health care professional under a physician's treatment plan. When a course of treatment is expected to be ongoing and extends beyond a two-week period, evaluation is required at two-week intervals by the licensed health care professional.

4. **Airborne infectious disease** in a communicable state that requires isolation of the individual or requires special precautions by the caretaker to prevent transmission of the disease, including diseases such as tuberculosis and excluding infections such as the common cold.

5. Psychotropic medications **without appropriate diagnosis and treatment plans.** Psychopharmacologic or psychotropic drugs include any drug prescribed or administered with the intent of controlling mood, mental status, or behavior. They include such drug classes as antipsychotic, antidepressants, and the anti-anxiety/hypnotic class. Examples include, but are not limited to, Amytal, Atarax, Ativan, Benadryl, Clozaril, Dalmane, Depakene, Depakote, Desyrel, Effexor, Elavil, Haldol, Librium, Lithium, Luvox, Klonopin, Mellaril, Navane, Norpramine, Pamelor, Paxil, Prozac, Remeron, Restoril, Risperdal, Seroquel, Serax, Serzone, Stelazine, Thorazine, Tofranil, Tranxene, Valium, Vistaril, Wellbutrin, Xanax, Zoloft, and Zyprexa.
6. **Nasogastric tubes:** A nasogastric tube is a feeding tube inserted into the stomach through the nose. It is used when the individual is unable to manage oral nutrition or feeding.
7. **Gastric tubes except when the individual is capable of independently feeding himself or herself and caring for the tube.** Gastric tube feeding is the use of any tube that delivers food/nutritional substances/fluids/medications directly into the gastrointestinal system. Examples include, but are not limited to, gastrostomy tube (GT), jejunostomy tube (JT), and percutaneous endoscopic gastrostomy tube (PEG).
8. **Individuals presenting an imminent physical threat or danger to self or others.** Imminent physical threat cannot be classified by a diagnosis; the determination is made based upon the behavior of the resident.
9. **Individuals requiring continuous licensed nursing care (seven days a week, twenty-four hours a day).** Continuous licensed nursing care means around-the-clock observation, assessment, monitoring, supervision, or provision of medical treatment by a licensed nurse. Residents requiring continuous licensed nursing care may include:
 - a. Individuals who have a medical instability due to complexities created by multiple, interrelated medical conditions; or
 - b. Individuals with a health care condition with a high potential for medical instability.
10. **Individuals whose physician certifies that placement is no longer appropriate.**
11. **Unless the individual's independent physician determines otherwise, individuals who require maximum physical assistance as documented by the UAI and meet Medicaid nursing facility level of care criteria as defined in the State Plan for Medical Assistance. Maximum physical assistance means that an individual has a rating of total dependence in four or more of the seven activities of daily living as documented on the uniform assessment instrument. An individual who can participate in any way with the performance of the activity is not considered to be totally dependent.**
12. **Individuals whose health care needs cannot be met in the specific assisted living facility as determined by the residence.**

Private Pay Individuals Only/Exceptions to the above: At the request of the private pay individual, care for the conditions or care needs specified in (3) and (7) above may be provided to a individual in an ALF by a physician licensed in Virginia, a nurse licensed in Virginia under a physician's treatment plan, or by a home care organization licensed in Virginia when the resident's independent physician determines that such care is appropriate for the resident. These exceptions do not apply to AG recipients. When care for a resident's special medical needs is provided by licensed staff of a home care agency, the ALF staff may receive training from the home care agency staff in appropriate treatment monitoring techniques regarding safety precautions and actions to take in case of emergency.

ASSISTED LIVING FACILITY CRITERIA

The criteria for assessing an individual's eligibility for public payment for ALF care and services consists of the following components:

- Functional capacity (the degree of assistance an individual requires to complete activities of daily living or instrumental activities of daily living);
- Medication administration; and
- Behavior pattern/orientation.

In order to qualify for public payment for ALF care, an individual must meet the criteria described below:

Criteria for Residential Living

Individuals meet the criteria for residential living as documented on the UAI when at least one of the following describes their functional capacity:

- Rated dependent in only one of seven ADLs (i.e., bathing, dressing, toileting, transferring, bowel function, bladder function, and eating/feeding) (page 4 of UAI).
- Rated dependent in one or more of four selected IADLs (i.e., meal preparation, housekeeping, laundry, and money management) (page 4 of UAI).
- Rated dependent in medication administration (page 5 of UAI).

TIP: Criteria for Residential Living Care: Dependent in one of seven ADLs; or Dependent in one or more of four selected IADLs; or Dependent in medication administration.

Independent Living Status

Individuals who are assessed as independent can be admitted into an ALF. A person does not have to meet the residential level of care criteria to live in an ALF licensed for residential care. In other words, the adult does not have to be dependent in any of the activities or instrumental activities of daily living or in medication administration or behavior to be an

ALF resident. Individuals who are assessed as independent are NOT eligible for AG payments unless they were public pay residents prior to February 1, 1996. Persons who are independent do not need the services provided by an ALF and therefore cannot receive public monies for those services, except for those who became public pay residents under the previous regulation and have been grandfathered.

Criteria for Assisted Living

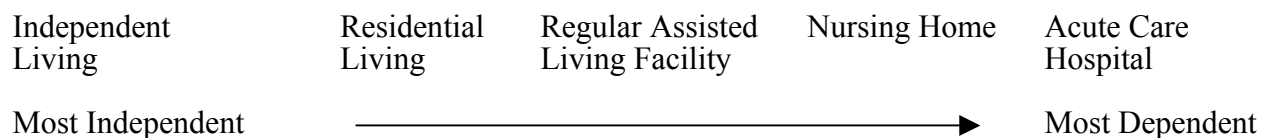
*TIP: Criteria for Assisted Living:
Dependent in two or more of seven ADLs; or
Dependent in behavior pattern.*

Individuals meet the criteria for assisted living as documented on the UAI when at least one of the following describes their capacity:

- Rated dependent in two or more of seven ADLs (page 4 of UAI).
- Rated dependent in behavior pattern (i.e., abusive, aggressive, or disruptive) (page 8 of UAI).

Continuum of Care

The following illustrates the continuum of care from independent living to more dependent levels of care. It should be noted that care can, in some instances, be more dependent in a lower level of care; this continuum illustrates the usual course of dependency in care provided. Individuals may, of course, move to a more independent level of care as well as move to a more dependent level.



Differences between NHPAS (Nursing Home Preadmission Screening) and ALF Assessments

NHPAS

- Assessors limited to LDSS and local health departments or hospital providers.
- Team concept with physician signature required.
- Social worker and registered nurse complete the assessment.
- UAI, DMAS-96, DMAS-97, and Level II screening for conditions of mental illness and/or mental retardation required.
- Reimbursement is split among community-based screeners.

ALF Assessments

- Expands providers to other public agencies and physicians.
- No team required; the individual assessor may seek professional assistance as needed. No physician signature required.
- Assessor must have the knowledge, skills, and abilities of a case manager.

- Forms required are the UAI and DMAS-96.
- There is no reimbursement split.

AUTHORITY FOR AUTHORIZATION OF PUBLIC PAYMENT

TIP: Assessors designated by law have the authority for authorizing public reimbursement for ALF services.

After the assessor has completed an assessment and established a level of care, the assessor is responsible for authorizing the appropriate services. During the authorization process, the assessor, with input from the individual being assessed, will decide what services, if any, are needed; who will provide the services; and the setting where services will be provided. The assessor will identify the available community services and make referrals as appropriate. The appropriate level of care must be documented on the Long-Term Care Preadmission Screening Authorization (DMAS-96).

In those instances when the assessment documentation does not clearly indicate that the individual meets ALF criteria, public funding for these services cannot be authorized. Any information that is needed to support the assessor's level-of-care decision must be documented on the UAI.

DMAS does, however, have the ultimate responsibility for assuring appropriate placement and thus can overturn any decision made by the assessor. Any authorization made by the assessor is subject to change based on any change that occurs in the individual's condition or circumstances between the time the authorization occurs and the service provider initiates contact with the individual. All applicants to and residents of ALFs for which assessment and/or targeted case management services are provided have the right to appeal the outcome of any assessment. See the "Right to Appeal" section at the end of this chapter for additional information.

Assurance that Appropriate Care Can Be Provided by the ALF

Prior to placement in an ALF, the assessor should contact the ALF to discuss the level of care needed and to ensure that the ALF has the appropriate licensing and has a valid contract with DMAS. The assessor must also discuss with the ALF staff the types of services needed by the applicant and determine whether the ALF is capable of providing the required services or that they are available in the community.

Once the placement is finalized, the assessor must notify the financial eligibility worker responsible for determining the AG payment of the effective date of admission using the DMAS-96. It is the current assessor's responsibility to ensure that the required reassessments are completed, whether by completing them him- or herself or referring them to another assessor.

Physical Examination

VDSS Licensing regulations require that all admissions to an ALF have a physical examination completed prior to the admission. VDSS Licensing has prepared a model form, "Report of the Physical Examination," which may be used for the physical examination. The use of this form is not required; any physical examination form that addresses the

requirements is acceptable (i.e., includes tuberculosis status, etc.). It is the responsibility of the ALF, not the assessor, to ensure that the physical examination is completed. The physician is not required to sign the UAI, but would still have to sign the physical examination report.

If the same person completes both the UAI and the physical examination report, it is not necessary to repeat the same information on the physical examination that is also on the UAI. The assessor may make reference to the UAI (e.g., “see UAI”) only for that information needed on the physical examination report which is the same as the information provided on the UAI. All other parts of the physical examination report must be completed.

Home Health Care in the ALF

When care of a resident’s special medical needs is provided by licensed staff of a home care agency, the ALF staff may receive training from the home care agency staff in appropriate treatment monitoring techniques regarding safety precautions and actions to take in case of emergency. If a public pay resident has special needs that can be provided by a home health agency, DMAS may reimburse for these services after a review to determine if the services fall within DMAS’ guidelines for home health services. Public pay recipients with one of the prohibited conditions cannot stay in an ALF, and DMAS will not reimburse for home health services in this case and may retract payment for services that have already been rendered.

Hospice Care in the ALF

Notwithstanding the *Code of Virginia*, § 63.2-1805 (the section that includes prohibited conditions), at the request of the resident, hospice care may be provided in an ALF if the hospice program determines that such program is appropriate for the resident.

OUTCOMES OF ALF ASSESSMENTS

The possible outcomes from ALF assessment may include:

- A recommendation for ALF care;
- Referral to a nursing home preadmission screening (NHPAS) team to review if the individual is appropriate for Medicaid-funded community-based care or nursing facility care;
- Referrals to other community resources (non-Medicaid-funded) such as health services, adult day care centers, home-delivered meals, etc.; or
- A determination that services are not required.

INITIAL ASSESSMENT PACKAGE

When a recommendation is made that an individual meets ALF level of care (either residential care or assisted living care services), the assessor will document this decision on the UAI and the Long-Term Care Preadmission Screening Authorization (DMAS-96) and prepare an assessment package. The initial assessment package is sent to:

First Health Services
P.O. Box 85083
Richmond, Virginia 23285-5083

The initial assessment package sent to First Health Services must include:

- **DMAS-96** (Long-Term Care Preadmission Screening Authorization). On the DMAS-96, #11 will be indicated for residential living care and #12 for regular assisted living. If #12 is authorized, the assessor must also enter the ALF provider number and date of the ALF start of care. If the individual requires Medicaid-funded targeted ALF case management, this would also be indicated. Also note the effective date of authorization. The assessor writes his or her agency's provider number in the first line of the space for "Level I Screening Identification" on the DMAS-96. The second line is used for NHPAS only.
- **Uniform Assessment Instrument (UAI)**, either short form or long-form, as appropriate. A copy of the UAI is acceptable.

In addition to the initial assessment package, the assessor must distribute the following:

- **To the LDSS Eligibility Worker**, the assessor must send a copy of the DMAS-96 to verify eligibility. (The city or county within the state where the person last lived outside of an institution or adult family/foster care home determines AG eligibility. As such, the assessor must send a copy of the DMAS-96 to the appropriate LDSS eligibility worker based on where the individual lived prior to placement in a facility.) The eligibility worker does not need to receive a copy of the UAI.
- **To the ALF**, the assessor sends the original UAI, DMAS-96, and decision letter. (See Exhibits 2-4.)
- **To the individual being assessed**, the assessor sends a decision letter.
- **The assessor** keeps copies of the UAI, DMAS-96, consent form, and decision letter. (If a change in level of care is indicated, then a new assessment is needed. The screening for nursing facility placement is limited to the current community-based screening teams or hospital discharge planners.)

REFERRALS TO MEDICAID-FUNDED COMMUNITY-BASED CARE OR NURSING FACILITY

Community-based care (CBC) or nursing facility services may be considered when the assessor completes an assessment and determines that an individual meets the criteria for nursing facility care and is at risk of nursing facility placement unless additional help is received. If the assessor feels that community-based care or nursing facility services are needed, the assessor must refer the individual for authorization of these services. CBC services include AIDS/ARC (Acquired Immune Deficiency Syndrome/AIDS-related complex) services, personal care, adult day health care, and respite care. Hospital screening

teams can authorize all services, but must have a physician's signature for community-based care or nursing facility authorizations.

If the assessor is a local department of social services, the UAI is referred to VDH (Virginia Department of Health) who will need to make an on-site visit and complete the authorization on the DMAS-96. Both parties will be reimbursed at the nursing facility (NF) assessment rate (\$69 to VDH; \$31 to VDSS). The assessment is considered a NF assessment; no additional payment is made for the ALF assessment.

If the assessor is another local public human services agency (i.e., AAA, CSB, or CIL) or a physician, but not a local department of social services, the UAI is referred to VDH and becomes a nursing home preadmission screening. All NHPAS procedures, including a home visit, are required. The original assessor will complete the DMAS-96, indicating "None" for services recommended and submit the paperwork to DMAS for payment. VDH and the local department of social services will be reimbursed as a NHPAS for completing a NF assessment by completing a different DMAS-96.

When state MH/MR facility staff determines that an individual requires nursing facility placement or Medicaid-funded community-based services, they shall follow the current NHPAS process that is to send the paperwork to DMAS for authorization of nursing facility or community-based care services.

If the assessor is a member of a hospital screening team, the physician must sign the DMAS-96 to meet the requirements of a NHPAS.

DMAS staff will know whether to reimburse as an ALF or NHPAS assessment by determining if there are one or two provider numbers listed on the DMAS-96. If a NHPAS team assesses an individual for NF services, and it is determined that ALF services are needed, the team would be reimbursed at the NHPAS rate.

Under current statutory requirements, assessments completed by AAAs, CSBs, CILs, state MH/MR facilities, physicians, or state correctional facilities will be accepted as authorizations only for residential or assisted living services. The local NHPAS team may authorize any of the services in the continuum of long-term care, including admission to an ALF. It is, therefore, important that all assessors attempt to determine during intake whether the person may require nursing facility placement or a Medicaid-funded community-based service. If so, assessors who are not authorized to perform NHPAS should refer the individual to a local NHPAS team to complete the assessment.

There may be occasions when, despite attempts to identify this as a possibility prior to completing an assessment, assessors not authorized to perform NHPAS complete an assessment for services in an ALF and determines at the conclusion of the assessment that the person requires nursing facility placement or could stay at home with personal care. If this occurs, the agency should forward the assessment to the local health department that will review the assessment and determine appropriateness of nursing facility placement or community-based care. Unless the information appears to be inconsistent or incomplete, the health department should only have to review the work already completed and issue the appropriate authorization. Upon authorization, the health department forwards the authorization to DMAS and to the assessor who completed the assessment for possible ALF

admission. In these cases only, the AAA, CSB, CIL, state MH/MR facility, or physician completing the assessment will be reimbursed.

If, upon review, the health department determines that additional information is needed which requires either another home visit or significant use of resources to obtain needed information, the health department should retain a copy of the assessment and return a copy to the ALF assessment agency. The ALF assessment agency should note on the assessment what has happened and that the health department will be completing an assessment for nursing facility or community-based care. The ALF assessment agency will then complete a DMAS-96 indicating an authorization of “None” for services recommended. The assessment and DMAS-96 can be submitted to DMAS for reimbursement. The health department may submit a revised assessment with the appropriate authorization on a DMAS-96 once its process is completed and be reimbursed for that assessment. DMAS does not expect that this will happen except rarely and will follow-up with the ALF case management agency to determine why the assessment completed by the agency was not sufficient to allow an authorization by the health department.

DMAS has the right to deny payment for any assessment that has not been completed according to DMAS policies and procedures.

REFERRALS TO COMMUNITY RESOURCES (NON-MEDICAID-FUNDED)

When the assessor determines that an individual requires assistance in the home and can be adequately maintained by a community service or combination of services, the assessor will initiate referrals. Depending upon the type of service required, the assessor will make the referral to the appropriate agency and assure that the individual and family understand how to receive services.

It is essential for assessors to maintain current information on available community resources, such as health services, licensed ALFs, adult day care centers, home-delivered meals, etc., to assist in developing alternatives to long-term institutionalization.

When referrals are made to non-Medicaid-funded community services, the assessor completes the following:

- **DMAS-96.** (On the DMAS-96, #8, “Other Services Recommended” would be authorized and the reason and resources to be used will be documented on the UAI.
- **UAI**, either short or long form as appropriate.

The assessment package is sent to:

First Health Services
P.O. Box 85083
Richmond, Virginia 23285-5083

In addition to the initial assessment package, the assessor must distribute the following information:

- **To the community service agency**, the assessor sends a copy of the UAI and the Consent to Exchange Information form.
- **To the individual being assessed**, the assessor sends a decision letter (see Exhibits).
- **The assessor** keeps copies of the UAI, the DMAS-96, consent form, and decision letter.

DETERMINATION THAT SERVICES ARE NOT REQUIRED

When the assessor determines that an individual is fully self-care or can be safely and adequately maintained in the home with assistance from relatives, friends, or neighbors and requires no additional monitoring or supervision, the assessor makes no referrals.

When no referrals for services are required, the assessor completes the following assessment package:

- **DMAS-96.** On the DMAS-96, #0, "None" would be authorized; document reason on the UAI.
- **UAI**, either short or long form as appropriate.

The assessment package is sent to:

First Health Services
P.O. Box 85083
Richmond, Virginia 23285-5083

In addition to the initial assessment package, the assessor must distribute the following information:

- **To the LDSS Eligibility Worker**, the assessor must send a copy of the DMAS-96.
- **To the individual being assessed**, the assessor sends a decision letter.
- **The assessor** keeps copies of the UAI, DMAS-96, the consent form, and decision letter.

CHANGES IN LEVEL OF CARE

The UAI must be completed or updated as needed whenever there is a significant change in the resident's condition that is expected to last more than 30 days or appears to warrant a change in the resident's approved level of care. A change in level of care assessment should be conducted within two weeks of receipt of the request for assessment when a permanent change in level of care is indicated, including when the resident presents with one or more of the prohibited conditions as described earlier in this chapter or no longer meets level of care criteria for which he or she was most recently assessed.

Who Can Complete an Assessment for a Change in Level of Care?

The following entities can perform an assessment for a change in level of care assessment:

- Local departments of social services;
- Area agencies on aging;
- Centers for independent living;
- Community services boards;
- Local departments of health;
- State facilities operated by DMHMRSAS;
- Acute care hospitals;
- An independent physician contracting with DMAS to complete the UAI for residents of ALFs; or
- DMAS staff during an on-site review.

TIP: Temporary changes in an individual's condition are those that can be reasonably expected to last less than 30 days.

Temporary Changes in Condition

Temporary changes in an individual's condition are those that can be reasonably expected to last less than 30 days. Such changes do not require a new assessment or update. Examples of such changes are short-term changes that resolve with or without intervention, changes that arise from easily reversible causes such as a medication change, short-term acute illness or episodic event, or a well-established, predictive, cyclic pattern of signs and symptoms associated with a previously diagnosed condition where an appropriate course of treatment is in progress.

Significant Changes in Condition Expected to Last Longer than 30 Days

When a level of care for a public pay resident has changed as documented on the UAI, the assessor must immediately notify the financial eligibility worker of the date of the assessment. If there is a change in level of care, and the ALF is licensed for the new level, then the ALF would receive payment for the new level of care based on the effective date of authorization on the DMAS-96.

Reimbursement for a Change in Level of Care Assessment

In order to be reimbursed for an assessment for change in level of care, the assessor must send to DMAS the following:

- **DMAS-96.** On the DMAS-96, indicate the change in level of care determination as follows: #11 for residential living; #12 for regular assisted living. See the DMAS-96 for other options.
- **UAI**, short or long form as appropriate.

The assessment package is sent to:

First Health Services
P.O. Box 85083
Richmond, Virginia 23285-5083

In addition to the above, the assessor must distribute the following information:

- **To the LDSS Eligibility Worker**, the assessor must send a copy of the DMAS-96.
- **To the ALF**, the assessor sends the original UAI and the DMAS-96.
- **To the individual being assessed**, the assessor sends a decision letter.
- **The assessor** keeps copies of the UAI, DMAS-96, and the decision letter.

If the ALF is licensed for assisted living, has a contract with DMAS, and the care need is authorized by an authorized assessor, then the ALF may receive payment as indicated. However, a change in level of care is only authorized by completing the UAI and a new DMAS-96. An assessment for a change in level of care is not conducted for temporary changes expected to last less than 30 days.

REIMBURSEMENTS TO THE ASSESSOR FOR INITIAL ASSESSMENTS AND CHANGES IN LEVEL OF CARE

Reimbursement for initial assessments and changes in level of care will be based upon the submitted admission package information similar to the current NHPAS process. In order to receive reimbursement for assessments, the authorized assessor must have a signed DMAS provider agreement and provider number. The provider number must be noted on the DMAS-96 to indicate to whom the payment should be made. See Chapter VI for instructions on the reimbursement process.

TIME LIMITATION ON ASSESSMENTS

An authorized assessor's approval decision regarding an individual's appropriateness for ALF placement is valid for twelve months or until an individual's functional or medical status changes, and the change indicates the individual may no longer meet the authorized level of care criteria.

If the current ALF residents have been assessed with the UAI by any public human services agency, and the assessment is less than 12 months old, it is not necessary to complete a new UAI.

TIP: UAI's completed within the last 90 days will be honored for new admissions.

New assessments are not needed when a current assessment has been completed within 12 months and no change in level of care has occurred for the following situations: 1) lapse in financial eligibility; 2) transfer from one ALF to another; 3) respite care residents; or 4) discharge back to the ALF from the hospital.

RIGHT OF APPEAL

Assessors must advise, orally and in writing, all applicants to and residents of ALFs for which assessment and/or targeted case management services are provided of the right to appeal the outcome of the assessment, the annual reassessment, or determination of level of care. AG applicants who are denied AGs because the assessor determines that they do not require the minimum level of services offered in the residential care level have the right to file and appeal with VDSS. A determination that the individual does not meet the criteria to receive assisted living services, or Medicaid-funded ALF targeted case management services is an action that is appealable to DMAS.

Any action taken by an assessor which affects the individual's receipt of services administered by the Medicaid program is an action which is appealable to DMAS. The assessor, by letter, must inform the individual and the referral source of the assessment decision to authorize or deny Medicaid payment for long-term care services and indicate the reason(s) for the decision. Any individual wishing to appeal should notify the Appeals Division, DMAS, in writing, of his or her desire to appeal within 30 days of the receipt of the assessor's decision letter. The following statement must be included in every decision letter (denial or approval):

“You may appeal this decision by notifying, in writing, the Appeals Division, Department of Medical Assistance Services, 600 East Broad Street, Suite 1300, Richmond, Virginia 23219. This written request for an appeal must be filed within thirty (30) days of the date of this notification.”

Any request for an appeal received by the DMAS Appeals Division must be validated and a hearing scheduled with the appellant. A final decision on the appeal must be completed within 90 days of the date the request for an appeal is received. The Appeals Division will be responsible for determining the relevant parties to be involved in the hearing process. See Exhibits 2-4 at the end of this chapter for sample approval and denial letters.

If the individual wishes to appeal a decision to deny assisted living services, the assessor will be notified that a summary of his or her decision must be prepared, and an appeal hearing will be scheduled which the assessor must attend.

EXHIBIT 1: ASSESSMENT PROCESS

Step 1: Contact	Request for assessment is made. Assessor makes contact (via telephone) ASAP. Verify Auxiliary Grant (AG) eligibility or that application for AG has been made.
Step 2: UAI	Get consent to release information. Assessor completes short UAI. If UAI has been completed in last 90 days, and there are no changes, do not complete a new UAI. If the individual is rated dependent in 2 or more ADLs or is dependent in behavior, a full UAI is completed. Continue assessment process. If individual meets NF criteria, stop assessment process. Refer to NHPAS team for authorization of NF or CBC services. Any authorized assessor may complete the initial assessment (see Chapter 1).
Step 3: Prohibited Conditions	Assessor determines if individual has a prohibited condition. If no, indicate so on UAI and continue. If yes, document such on UAI. The AG recipient is NOT eligible for ALF placement if he or she has a prohibited condition. Stop assessment process and refer to other services.
Step 4: Determine Level of Care	Determine individual's level of care using ALF criteria (i.e., residential or assisted living). Complete DMAS-96 and prepare authorization letter about approval or denial of ALF services to the individual.
Step 5: ALF Availability/Case Management	Discuss with the individual his or her choice of ALF. Ensure that ALF has the appropriate license for the person's level of care and is enrolled as a Medicaid provider. Verify that ALF can provide requested services or if they are available in the community. Determine if the individual requires only the 12-month reassessment or ongoing Medicaid-funded targeted ALF case management services. If only 12-month reassessment, continue. If case management services needed, arrange for a case manager.
Step 6: Notifications for Initial Assessments & Level of Care Changes	To DMAS, send copies of DMAS-96 and UAI. To LDSS eligibility worker, send copy of DMAS-96. To ALF, send the DMAS-96 and UAI. To individual, send original decision letter. Assessor keeps copies of the UAI, DMAS-96, consent form, and decision letter. Assessment process must be completed within 2 weeks of receipt of the referral.
Step 7: Plan Reassessment	At least every 12 months, perform reassessment. Original assessor is responsible for reassessment; if unwilling or unable to do, original assessor is responsible to engage another assessor to do the reassessment. If original assessor is hospital staff, state facility staff, or a community release unit of a correctional facility, he or she must refer reassessment responsibility to another assessor ASAP. In this case, the new assessor must be identified at time of admission.
Step 8: Reassessment Notification	To DMAS, send copies of ALF Eligibility Communication Document, UAI, and HCFA-1500. To LDSS eligibility worker, send copy of ALF Eligibility Communication Document. To ALF, send the UAI and ALF Eligibility Communication Document. To individual, send decision letter. Assessor keeps UAI, ALF Eligibility Communication Document, and HCFA-1500.

EXHIBIT 2: SAMPLE APPROVAL ASSISTED LIVING FACILITY LETTER

Mrs. Mary Jones
0000 Avenue
Home Town, Virginia 00000

Dear Mrs. Jones:

Virginia regulation requires that any individual seeking admission to an assisted living facility (ALF) be assessed to determine if he or she meets the level of care for an assisted living facility prior to the individual's placement. You were assessed on _____ (date) and it was determined that you meet criteria for:

- ☐ Residential living
- ☐ Assisted living
- ☐ Ongoing Medicaid-funded targeted ALF case management

Once the assessor determines an individual meets the criteria for assisted living facility admission, the assessor considers the appropriate setting for the delivery of care.

The assessor, in accordance with policy and procedures of the Department of Medical Assistance Services, has determined that you meet the level-of-care criteria necessary for assisted living facility placement. The assessor discussed with you the choice of facility services, and it was determined that assisted living facility placement would best meet your needs at the present time. The assessor is responsible for assessing your needs upon admission and, you will be assessed periodically thereafter in order to demonstrate that you continue to meet the criteria.

You may appeal this decision within thirty (30) days of receipt of this decision letter by writing to the Recipient Appeals Unit, Department of Medical Assistance Services, Suite 1300, 600 East Broad Street, Richmond, Virginia 23219.

Sincerely,

Assessor

**EXHIBIT 3. SAMPLE DENIAL LETTER FOR ALF REGULAR ASSISTED LIVING
OR ONGOING MEDICAID-FUNDED TARGETED ALF CASE MANAGEMENT**

Mrs. Mary Jones
Address

Dear Mrs. Jones:

As an applicant/recipient of an Auxiliary Grant, you must be determined to need the level of care offered by an assisted living facility (ALF). You were assessed on _____ (date) and it was determined that you do not meet criteria for:

- ☐ Residential living
- ☐ Assisted living
- ☐ Ongoing Medicaid-funded targeted ALF case management

The reason you were determined not to meet the criteria for the above-checked item is (*note specific reason why the individual does not meet the criteria*).

If you do not agree with this decision, you may write or call me to request a conference. If, after the conference, you still do not agree with the decision, you may request a hearing. If you do not want a conference, you may request a hearing without having a conference.

You must request a hearing within 30 days of the date this notice is postmarked. The hearing is a private, informal meeting with you, anyone you wish to bring, a Hearing Officer, and me. You will have the opportunity to tell the impartial Hearing Officer, who is a representative of the Virginia Department of Medical Assistance Services, why you disagree with the above decision. Your request must be mailed to:

Recipient Appeals Unit
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

Sincerely,

Assessor

c: Director, Appeals Division, DMAS
Individual's Legal Guardian

**EXHIBIT 4. SAMPLE APPEALS LETTER FOR INDIVIDUAL NOT MEETING
MINIMUM RESIDENTIAL ALF LEVEL OF CARE**

Date _____
Individual's Name/Address _____

Dear _____ :

As an applicant/recipient of an Auxiliary Grant, you must be determined to need the level of care offered by an assisted living facility (ALF). You were assessed on _____ (date) and it was determined that you do not meet the minimum residential level of care guidelines because *(note specific reason why the individual does not meet the level of care)*.

If you do not agree with this decision, you may write or call me to request a conference. If, after the conference, you still do not agree with the decision, you may request a hearing. If you do not want a conference, you may request a hearing without having a conference.

You must request a hearing within 10 days of the date this notice is postmarked. The hearing is a private, informal meeting with you, anyone you wish to bring, a Hearing Officer, and me. You will have the opportunity to tell the impartial Hearing Officer, who is a representative of the Virginia Department of Social Services, why you disagree with the above decision. Your request must be mailed to:

Manager, Appeals and Fair Hearings
Virginia Department of Social Services
730 East Broad Street
Richmond, Virginia 23219

If you need help to request a hearing or appeal, please contact your service worker.

Sincerely,

Assessor

c: Manager, Appeals and Fair Hearings, VDSS
Individual's Legal Guardian

**EXHIBIT 5. ALF ORIENTATION/BEHAVIOR PATTERN
DETERMINATIONS**

	Behavior				
Orientation	Appropriate	Wandering/Passive Less Than Weekly	Wandering/ Passive More Than Weekly	Abusive/Aggressive/ Disruptive Less Than Weekly	Abusive/Aggressive/ Disruptive More Than Weekly
Oriented	I	I	I	d	d
Disoriented --Some spheres --Some of the time	I	I	d	d	D
Disoriented --Some spheres --All of the time	I	I	d	d	D
Disoriented --All spheres --Some of the time	d	d	d	d	D
Disoriented --All spheres --All of the time	d	d	d	d	D

I=Independent

d=Semi-dependent

D=Dependent

CHAPTER III: SPECIAL ASSESSMENT FACTORS

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CHANGES IN FINANCIAL ELIGIBILITY STATUS OF AN ASSISTED LIVING FACILITY RESIDENT

When a Private Pay Resident Becomes an Auxiliary Grant Recipient

When a private pay resident of an assisted living facility (ALF) becomes an Auxiliary Grant (AG) recipient, the local department of social services (LDSS) eligibility worker will advise the resident of program requirements which include the need for an assessment. Eligibility should go back to the jurisdiction from where the resident came. All assessment procedures must be followed. The public human services agency providing the assessment will be reimbursed at the initial assessment rate of \$25 for a short assessment and \$100 for a full assessment. If an individual has had a private pay UAI completed, and he or she becomes eligible for an AG, a public pay UAI must be completed in order to services to be authorized.

The eligibility worker will advise the applicant to which agency to go for an assessment using the public pay UAI. The eligibility worker of jurisdiction must be provided with a copy of the Long-Term Care Preadmission Screening Authorization (DMAS-96) for verification of the assessment. If there is a full UAI on record (not the two-paged private pay version) that is less than twelve months old, the resident does not need to be reassessed unless there is indication that his or her level of care has changed.

When an AG Recipient Becomes a Private Pay Resident

If the resident becomes ineligible for an AG based on income or countable resources, the eligibility worker will issue a notice of adverse action to the recipient eleven days in advance of the action to terminate the AG. The ALF and the resident must determine whether the former AG recipient continues to reside in the ALF. If there were an ongoing case manager, the case manager would participate in the discharge planning process, if appropriate, and then terminate case management services. If ongoing case management is not being provided, the agency completing the level of care assessment should assist the ALF, if necessary, in discharge planning. If the resident continues to reside in the ALF as a private pay resident, assessment requirements for private pay residents must be followed.

GENERAL RELIEF RECIPIENTS

Unlike AG recipients, General Relief (GR) recipients are not Medicaid eligible. Regulation defines private pay individuals as those who are not AG recipients or eligibles. All others are considered to be private pay. Payment for assisted living services for GR recipients in public ALFs, (i.e., district homes) is allowed. The assessment of these GR recipients can be treated like AG recipients in that DMAS will reimburse a public assessor \$25 for a short assessment and \$100 for a full assessment.

DISCHARGE AND TRANSFER OF AN ALF RESIDENT

Discharge is the process that ends the stay in an ALF. Staff of the ALF must plan for post-discharge services when the resident is returned to a home-based placement, a nursing facility, or a mental health or mental retardation facility. ALF staff must notify the local department of social

services' financial eligibility worker in the jurisdiction responsible for authorizing the AG of the date of discharge and also notify the case manager, if applicable.

When a resident moves to an ALF from another ALF, a new UAI is not required except that a new or updated UAI must be completed whenever there is a change in the resident's condition that appears to warrant a change in the resident's approved level of care or the 12-month reassessment is due within 30 days of the transfer. The original ALF should forward a copy of the current assessment material to the new ALF. An updated UAI is required:

1. For the movement of a resident from one ALF to another ALF when there is a change in level of care; or
2. For the movement of an ALF resident to a nursing facility or Medicaid community-based waiver program (e.g., personal care). The updated UAI must be forwarded to the health department on the local preadmission screening committee where the ALF is located for review and authorization of services. Placement authorization is documented by sending a completed DMAS-96 to the local department of social services of jurisdiction.

When an ALF resident moves back to the community without Medicaid community-based services, an updated copy of the UAI may be forwarded to the local service provider if requested by the resident or his or her representative. All required discharge procedures must be followed. If an individual who resides in a nursing facility no longer meets nursing facility criteria, and that individual is screened for admission to an ALF, all ALF procedures must be followed.

OUT-OF-STATE INDIVIDUALS

Individuals who reside out of state and wish admission to Virginia ALFs must be assessed and authorized prior to public reimbursement for these services. The local department of social services in the locality of the ALF accepts the AG application for out-of-state individuals who seek admission to a Virginia ALF. If an out-of-state applicant is clearly private pay, the admitting ALF is responsible for the assessment. If the individual is likely to be eligible for an AG, the public human services assessor, such as the local department of social services, completes the assessment prior to the individual's admission. Information may be obtained by telephone interview if a face-to-face interview is not practicable, with a follow-up on-site visit after the admission.

EMERGENCY PLACEMENTS

An emergency is a situation in which an adult is living in conditions that present a clear and substantial risk of death or immediate and serious physical harm to self or others. In emergency placements, the UAI must be completed within seven working days from date of placement. Typically, an emergency placement will involve an adult who lives outside of an institution and not already in an ALF (22 VAC 40-745-10 et seq.).

Prior to the placement, the need for an emergency placement must be approved by a Virginia adult protective services (APS) worker or case manager for public pay individuals and documented in the records of the APS worker or case manager. (For private pay individuals, an independent physician may also approve the emergency placement.)

This is the **only** instance in which an individual may be placed in an ALF without first having been assessed to determine if he or she meets ALF level of care. When an emergency placement is made, the UAI and the DMAS-96 must be completed within seven working days from the date of the placement. There must be documentation in the resident's record at the ALF that a Virginia APS worker or case manager approved the emergency placement. A notation on the UAI signed by the APS worker or case manager will meet this requirement. The assessment must be completed by an appropriate assessor in the jurisdiction where the individual lived prior to the emergency placement.

TIP: Prior to an emergency placement, the need must be approved and documented by a Virginia APS worker or public agency case manager.

In the case of an emergency placement as defined in Chapter III, the assisted living authorization is considered effective as of the date of the emergency placement, provided that the Long-Term Care Preadmission Screening Authorization (DMAS-96) is signed and dated within seven working days after the date of the emergency placement.

The individual accepting the referral call should discuss the following issues to determine if an assessment is appropriate and if an emergency exists:

1. The name, address, and telephone number of the caller requesting the assessment as well as the individual to be assessed;
2. The relationship of the caller to the individual to be assessed;
3. The change in the individual's circumstances that would indicate that the individual can no longer reside in the home and if the individual to be assessed desires ALF placement;
4. The kinds of assistance the individual requires to complete the activities of daily living and the support available to the individual to provide assistance;
5. The specific medical problems and nursing needs and the name, address, and telephone number of the individual completing the preliminary assessment;
6. Whether the individual has any prohibited conditions that would exclude him or her from ALF placement;
7. Whether the individual to be assessed is receiving or has applied for an AG; and
8. Whether an assessment has been completed recently (see Chapter II, "Time Limitation on Assessments").

Prior to an emergency placement of an AG recipient, the APS worker or case manager must first discuss the placement with the receiving ALF to ensure that the ALF can provide the minimum services needed by the individual. The AG recipient believed to need an emergency placement does not need to be a current client of the agency in order for the agency to perform this function.

The Departments of Medical Assistance Services and Social Services will monitor the approval of emergency placements and have the right to deny or overturn any decision made for emergency placement. Emergency placements are to be used only when a true emergency can be documented and justified.

REQUEST FOR AN INDEPENDENT ASSESSMENT

An independent assessment is an assessment that is completed by an entity other than the original assessor; this may be another assessor within the same agency. At the request of the ALF, the resident's representative, the resident's physician, DSS, or the local department of social services, an independent assessment using the UAI is completed to determine whether the resident's care needs are being met in the current placement. An independent assessment is requested when one of the above entities questions the outcome of an assessment and desires a second assessment to be completed. The ALF shall assist the resident in obtaining the independent assessment as requested. If the outcome of the independent assessment is the same as the previous assessment, then the entity requesting the independent assessment may be held responsible for paying the independent assessment.

ASSESSMENT OF INDIVIDUALS WITH MENTAL HEALTH OR MENTAL RETARDATION NEEDS

Certain providers may be more appropriate to complete assessments than others. For example, a resident who is mentally ill or mentally retarded is more appropriately served by staff of a community services board (CSB). CSBs are expected to conduct the initial assessment, annual reassessment, and ongoing ALF targeted case management services for persons who may require mental health or mental retardation community services.

TIP: CSBs should conduct the initial assessment, annual reassessment, and ongoing targeted case management for persons who may require MH or MI community services.

It is the original assessor's responsibility to ensure that the required annual reassessments are completed. An assessor is responsible for securing another assessor if he or she cannot continue to assess the individual. The reassessment then becomes the responsibility of the new assessor.

ASSESSMENT OF INDIVIDUALS RECEIVING STATE PLAN OPTION CASE MANAGEMENT SERVICES FOR MENTAL HEALTH OR MENTAL RETARDATION

CSBs must also be involved in the assessment process for those clients already receiving Medicaid-funded state plan option (SPO) case management services for mental health or mental retardation. DMAS is funding two separate services for AG residents of ALFs: the initial assessment and

targeted case management services, which includes the annual reassessment. DMAS will reimburse all public human services agencies involved in the initial assessment of the AG residents of ALFs. However, DMAS will not reimburse targeted case management services for the same individual by more than one type of case management provider. Therefore, the following clarification is made for SPO clients:

1. Assessments (initial assessments and change in level of care assessment for current SPO case management clients):
 - a. All ALF applicants and current residents who are receiving SPO mental health or mental retardation case management services must receive their initial assessment, using the UAI, from the CSB agency providing the case management services. The CSB will be reimbursed for this initial assessment, either \$25 for a short assessment or \$100 for a full assessment.
 - b. ALF residents who are receiving SPO mental health or mental retardation case management services must receive change in level of care assessments from the CSB providing case management services. The CSB will be reimbursed for the change in level of care assessment, either \$25 for the short assessment or \$100 for a full assessment.
2. ALF Case Management (Annual assessment and ongoing case management services for current SPO mental health or mental retardation case management clients):
 - a. All residents of ALFs who are receiving SPO mental health or mental retardation case management services must receive their annual reassessment from the CSB providing the case management services. The CSB will not receive additional payment for this assessment because it is part of the SPO case management activities.
 - b. All residents receiving SPO case management services cannot also receive ALF targeted case management services.

As long as the client meets the criteria for the waiver services, the level of care assigned in an ALF should be appropriate for the client. A client can only receive one waiver service at a time.

REFERRAL FOR MENTAL HEALTH, MENTAL RETARDATION, OR SUBSTANCE ABUSE EVALUATION

When determining the appropriateness of ALF admission for individuals with serious mental illness, mental retardation, or a history of substance abuse, a current psychiatric or psychological evaluation may be needed. The need for this evaluation will be indicated on the UAI or based upon the recommendation of the individual's case manager or other assessor. The evaluation must be completed by a person having no financial interest in the ALF, directly or indirectly as an owner,

officer, employee, or as an independent contractor with the residence. A copy of the evaluation must be filed in the resident's record.

"Assisted living care" means of level of service provided by an ALF for adults who may have physical or mental impairments and require at least moderate assistance with the activities of daily living. While ALFs provide or coordinate personal and health care services, 24-hour supervision, and assistance, the ALF is not a treatment facility capable of providing therapeutic treatment services to residents.

The assessor must use his or her professional judgment when determining whether a referral is necessary, using the guidelines for mental health referrals found in the *User's Manual: Virginia Uniform Assessment Instrument*, "Indicators for Referral to the Department of Mental Health, Mental Retardation and Substance Abuse Services." If the ALF staff can provide adequate care, the individual may be admitted before the completion of his or her evaluation. In this case, a note must be entered in to the individual's record that he or she is awaiting evaluation.

The ALF must enter into a written agreement with the local community mental health, mental retardation, and substance abuse services board, a public or private mental health clinic, treatment facility, or agency to make services available to all residents. This agreement must be jointly reviewed annually by the ALF and the service entity. This requirement does not preclude a resident from engaging the services of a private psychiatrist or other appropriate professional. Services to be included in the agreement must comply with VDSS regulations. A copy of the agreement must remain on file in the ALF. For each resident, the services of the local community mental health, mental retardation, and substance abuse services board, or a public or private mental health clinic, rehabilitative services agency, treatment facility, or agent shall be secured as appropriate based on the resident's current evaluation. Staff from VDSS Divisions of Licensing Programs and Family Services may ensure that the agreement is in place.

Referral for Mental Illness Evaluation

A referral for an mental illness (MI) evaluation is made for a diagnosis of schizophrenia, personality disorder, mood disorder, panic, somatoform disorder, other psychiatric disorders, paranoid disorder, or other serious anxiety disorders AND when the individual exhibits distorted thought processes, mood disorders, OR maladaptive behavior manifested by 1) acts detrimental to self or others; 2) acts of abuse, aggression, or disruption; or 3) emotional status which interferes with functioning ability (e.g., agitation, fearfulness, or depression).

Referral for Mental Retardation Evaluation

A referral is made for a mental retardation evaluation if:

1. The individual has a condition of MR (IQ is 70-75 or below; age of onset is 18 years or below; there are significant limitations in two or more applicable adaptive skills areas such as communication, social skills, health and safety, work, self care, home living, community use, self-direction, functional academics, and leisure); OR

2. The individual has a suspected diagnosis of MR (received special education or did not complete school or has substantial functioning limitations in two or more of adaptive skills areas above); *OR*
3. The individual has a related condition (developmental disability) that is a severe, chronic disability attributable to mental and/or physical impairment that was manifested before age 22, is likely to continue indefinitely, and results in a substantial functional limitation in three or more major life activities such as self-care, receptive and/or expressive language, mobility, self-direction, and capacity for independent living or economic self-sufficiency.

Referral for Substance Abuse Evaluation

A referral for evaluation should be considered for further exploration when the individual reports current drinking of more than two alcoholic drinks per day or has current use of non-prescription mood altering substances such as marijuana, amphetamines, etc.

ADDITIONAL REQUIREMENTS FOR ALFS CARING FOR ADULTS WITH DEMENTIA/SERIOUS COGNITIVE DEFICITS

The ALF also has additional staffing/training requirements when any resident exhibits behavior indicating a serious cognitive deficit and when the resident cannot recognize danger or protect his or her own safety and welfare.

When determining the appropriateness of ALF admission, cognitive deficits should be noted on the UAI and communicated to the ALF. The ALF must determine if it can meet the needs of the resident.

ALF-TO-ALF TRANSFER

Individuals residing in an ALF and desiring a transfer to another ALF in the Commonwealth of Virginia are not required to be reassessed at the time of the transfer unless there has been a significant change in the resident's condition that would warrant a change in level of care or if the current assessment is more than twelve months old. **The ALF from which the individual is transferring must send a copy of all current assessment material to the receiving facility, the appropriate local eligibility worker, and to the individual's assessor.** The receiving ALF is then responsible to initiate the appropriate documentation for admission purposes. It is important to ensure that the new assessor be notified of the resident's transfer.

ALF-TO-NURSING FACILITY TRANSFER

The Nursing Home Preadmission Screening (NHPAS) committee in the locality of the ALF is responsible for the assessment and authorization of individuals who are ALF residents and who need nursing facility services. The ALF must schedule with the NHPAS Committee to complete a screening for the individual. The NHPAS committee handles this referral like any other referral coming from anywhere else in the community.

NURSING FACILITY-TO-ALF TRANSFER

A transfer from a nursing facility to an ALF is considered a change in level of care assessment and would be processed as such.

ALF-TO-HOSPITAL TRANSFER

Screening Committees in hospitals do not complete an assessment for individuals who are admitted to a hospital from an ALF when the individual is to be discharged back to either the same or a different ALF and the individual continues to meet the same ALF level of care or is expected to meet the same criteria for level of care within 30 days of discharge. In the event that the resident's bed has not been held at the ALF from which he or she left prior to being hospitalized, he or she would still not need to be evaluated by the hospital staff provided that he or she is admitted to another ALF at the same level of care. The hospital may, however, elect to perform the assessment, but is not required to do so.

If an individual is admitted to a hospital from an ALF and the individual's condition has not changed, but placement in a different ALF is sought, a new assessment is NOT required. The second ALF would be required to complete necessary documentation for admission.

If there has been a change in level of care since the individual's admission to the hospital, the hospital assessors could perform a change in level of care assessment (see Chapter II), unless the change is thought to be temporary.

If an individual is admitted from an ALF and the individual needs to transfer to Medicaid-funded community-based care, an assessment must be completed according to the nursing home preadmission screening policies and procedures.

ASSESSMENT OF PRIVATE PAY RESIDENTS

An alternate one-paged (front and back) assessment form has been developed for private pay residents. On this form, only information relevant to documenting level of care is collected. The common definitions that were developed for the UAI are also used for the private pay UAI. For additional information, refer to the *User's Manual: Virginia Uniform Assessment Instrument (UAI) for Private Pay Residents of Assisted Living Facilities*. This manual is available from the Virginia Department of Social Services, Adult Services Program, 730 East Broad Street, Richmond, Virginia 23219, telephone number 804-692-1299.

TIP: If an individual has had a private pay UAI completed, and becomes eligible for an AG, a public pay UAI and a DMAS-96 must be completed for services to be authorized.

INDIVIDUALS ASSESSED AND AWAITING ALF PLACEMENT

At times, an individual who has been assessed as appropriate for ALF care has to remain in the community while waiting for an ALF bed. Once a placement becomes available, and if no more than 90 days have elapsed, a new assessment does not have to be completed unless there has been a significant change in the resident's condition. If more than 90 days have elapsed since the assessment was conducted, then a new assessment must be completed.

MENTAL HEALTH/MENTAL RETARDATION FACILITY INPATIENTS

Individuals who are patients in state mental health and mental retardation facilities and who seek ALF placement directly from these facilities must be assessed. Qualified staff of the state facility will complete these assessments.

VETERANS ADMINISTRATION MEDICAL CENTERS

Individuals in Veterans Administration Medical Centers (VAMC) who are public pay individuals and who are applying to enter an ALF can be assessed by an assessor from a public human services agency in the locality in which the facility is situated or by a physician of the hospital if he or she is enrolled as a DMAS provider to assess ALF applicants and residents. The physician may designate qualified staff to complete the assessment; however, he or she must sign and approve the assessment.

RESPIRE CARE AND CONVALESCENT LEAVE

Individuals admitted to an ALF for respite care must be assessed. Respite care is a temporary stay in the facility, usually to relieve caregivers from their duties for a brief period of time. The initial assessment is valid for 12 months if the level of care of the individual remains the same. A reassessment would be required annually provided that the respite care continues to be provided, even if it is provided intermittently. AG clients are typically not admitted to an ALF for respite care. However, some state facilities discharge their clients to ALFs for “convalescent leave” to ensure that the placement is appropriate. These clients must also be assessed using the UAI prior to the initial admission to the ALF.

ASSESSMENT OF CORRECTIONAL SYSTEM INMATES

The responsibility for ALF assessments of adults leaving the correctional system lies with the local assessors in the locality of the prison facility; this may include trained assessors in Community Release Units or Department of Corrections designee of the correctional system. These assessors must have completed the Virginia Uniform Assessment Instrument (UAI) course offered by an approved entity such as the State or the Virginia Institute of Social Services Training Activities (VISSTA) at Virginia Commonwealth University. A certificate of successful completion of the course must be placed in the assessor’s personnel file. The correctional facility will not receive reimbursement from DMAS for conducting the ALF preadmission assessment. If a non-correctional facility assessor performs the assessment, the assessor is advised to contact the correctional facility prior to the assessment to get a sense of whether the adult meets nursing facility or ALF criteria. If the adult is determined to require nursing facility care, then the assessor must contact the local nursing home preadmission screening team for a nursing facility screening.

INDIVIDUALS DISCHARGED FROM AN ALF TO MEDICAID-FUNDED HOME AND COMMUNITY-BASED CARE

The NHPAS Committee in the locality of the ALF is responsible for assessment and authorization for individuals who are ALF residents and who could possibly return to the community with the assistance of Medicaid-funded community-based care services. The ALF will schedule with the NHPAS Committee to complete a screening for any individual who wishes to be discharged home. The NHPAS Committee handles this referral as it would a referral coming from anywhere else in the community.

MEDICAID-FUNDED HOME HEALTH SERVICES PROVIDED TO AUXILIARY GRANT RECIPIENTS

If an AG resident has special needs that can be provided by a home health agency, DMAS may reimburse for these services after a review to determine if the services fall within DMAS' guidelines for home health services. AG recipients with one of the prohibited conditions (see Chapter II) cannot stay in an ALF, and DMAS will not reimburse for home health services in this case.

CHAPTER IV: ANNUAL REASSESSMENT

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INTRODUCTION

The purpose of the annual reassessment is the reevaluation of service need and utilization review. The assessor or case manager shall review each resident's need for services annually, or more frequently as required, to ensure proper utilization of services. The outcome of this review shall be communicated to the LDSS eligibility staff, DMAS, the facility where the resident resides, and the resident. All ALF residents must be reassessed at least annually. All applicants for an AG must have an assessment completed before AG payment can be issued.

The annual reassessment is based upon the date of the last completed assessment. The reassessment does not need to be performed in the same month as the financial eligibility redetermination. The financial eligibility worker in the local department of social services will need to have documentation in the eligibility record that there is a current assessment on file. A current assessment is one that is not older than twelve months.

TIP: Reassessments must be completed twelve months from the previous assessment.

WHO CAN CONDUCT THE ANNUAL REASSESSMENT?

The following assessors can complete the annual reassessment:

- Local departments of social services
- Area agencies on aging
- Community services boards
- Centers for independent living
- Local departments of health
- Independent physician with a contract with DMAS

The annual reassessment is completed by:

- The assessor conducting the initial assessment (unless the original assessor is from an acute care hospital, State facility for MI/MR, or community release unit);
- The agency chosen by the resident for ongoing case management services; or
- The agency accepting the referral from the agency that completed the initial assessment. If no agency accepts the referral for reassessment, then the local department of social services where the resident resides, following placement in an ALF, is the assessor (except for residents receiving Medicaid-funded mental health case management services described below).

If a resident is receiving targeted case management services for mental illness or mental retardation, the agency case manager for this service must complete the reassessment as part of case management responsibilities for that individual. DMAS will not reimburse them additionally for the completion of the assessment. This case management will be noted on the individual's UAI at the time of the initial assessment and the mental health case manager will be

advised of the individual's authorization for ALF residence and the date when the reassessment is needed. The mental health case manager must complete the reassessment and follow the other directions for process of the annual reassessment.

ALF staff may not complete assessments, reassessments, or changes in level of care of ALF residents who are AG applicants or recipients. Designated ALF staff with documented training in the completion of the UAI may only complete assessments for private pay residents. Only public human services agencies that have a contract with DMAS may perform public pay assessments.

WHEN INITIAL ASSESSMENTS ARE COMPLETED BY ACUTE CARE HOSPITALS, STATE MH/MR FACILITIES, OR DEPARTMENT OF CORRECTIONS DESIGNEE

Acute care hospitals, state mental health/mental retardation facilities, and correctional facilities may not complete the 12-month reassessment or provide Medicaid-funded targeted ALF case management. These groups may perform the initial assessments or assessments for changes in level of care only.

TIP: The initial assessor's responsibility does not end until the referral is accepted by another assessor. It is the original assessor's responsibility to ensure that the required annual reassessments are completed.

It is the original assessor's responsibility to ensure that the required annual reassessments are completed. The assessor may refer the twelve-month assessment to another assessor, but no later than one month prior to the due date of the twelve-month assessment. An assessor is responsible for securing another assessor if he or she cannot continue to assess the individual. The reassessment then becomes the responsibility of the new assessor. Both the original assessor and the assessor to whom assessment responsibility is transferred should keep written communication. There is no required form for this communication.

When original assessments are completed by the acute care hospitals, state mental health/mental retardation facilities, and Community Release Units or Department of Corrections designee of correctional facilities, these responsibilities must be referred to another assessor as soon as possible, but no later than one month prior to the due date of the annual reassessment. The original assessor must send the original UAI, the DMAS-96, and the reassessment date to the new assessor and notify the eligibility worker in the jurisdiction that the resident resides. The ALF must also be aware of reassessment dates.

TIMING OF THE REASSESSMENT

In scheduled reassessments, DMAS will reimburse for assessments that are completed as soon as ten (10) months from the previous assessment. An annual reassessment following an initial assessment that was completed on April 27, 2002, for example, could be completed as early as February 27, 2003, and will be reimbursed. If a reassessment were completed prior to February 27, 2003, in this example, the DMAS reimbursement system would reject the request for reimbursement.

WHAT IS COMPLETED FOR THE ANNUAL REASSESSMENT PACKAGE?

For annual reassessments, the assessor completes the following:

1. **Assisted Living Facility Eligibility Communication Document** (shown in Appendix C). This form will notify the local eligibility worker in the LDSS where AG eligibility is determined that the resident continues to meet either residential or assisted living so that AG eligibility can be redetermined. On the form, indicate that the reassessment is completed, whether the resident continues to meet criteria for ALF level of care. If the individual no longer resides in the ALF, indicate such in the space provided;
2. **Uniform Assessment Instrument (UAI)**, either short-form or long-form, as appropriate. If the assessor chooses not to complete a new UAI form and updates the existing UAI for the annual reassessment, the assessor must be sure that the copy submitted to DMAS for processing and data entry clearly indicates that it is a reassessment. (This may be done using a highlighter or colored ink at the top of the first page.) Only the initial assessment and one reassessment is permitted on UAI's submitted to DMAS. In addition, any changes that are made to the form must be clearly noted (as with a highlighter or colored ink) so that the changes will be easily recognized; and
3. **HCFA-1500**: This completed billing invoice must be sent in order for the assessor to be reimbursed (except for MH/MR case management clients). See Chapter VI for billing instructions.

Please note that the DMAS-96 is NOT sent with an annual reassessment.

The annual reassessment package is sent to:

First Health Services
P.O. Box 85083
Richmond, VA 23285-5083

In addition to sending the above package to First Health Services, the assessor must distribute the following information:

1. **To the LDSS Eligibility Worker**, the assessor must send a copy of the Assisted Living Facility Eligibility Communication Document.
2. **To the ALF**, the assessor sends the original UAI and the Assisted Living Facility Eligibility Communication Document.
3. **To the individual being assessed**, the assessor sends a decision letter.

4. **The assessor** keeps a copy of the UAI, the Assisted Living Facility Eligibility Communication Document, and the HCFA-1500.

If, during the reassessment, it is determined that a change in level of care has occurred, the assessor must treat the assessment not as a reassessment, but as a change in level of care. This means that the UAI and DMAS-96 are completed and not the ALF Eligibility Communication Document or the HCFA-1500. See Chapter II for more information on changes in levels of care.

See Chapter VI for additional information on submitting the annual reassessment package to DMAS for reimbursement.

CHAPTER V: ONGOING TARGETED CASE MANAGEMENT

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INTRODUCTION

The purposes of Medicaid-funded ALF case management are:

1. To assure the appropriate placement of individuals in ALFs.
2. To assure that appropriate payment is made to the ALFs.
3. To provide basic monitoring of the continued appropriate placement of residents and payment for their care in an ALF.

There are two types of Medicaid-funded case management services for ALF residents:

1. Annual reassessment only; or
2. Ongoing targeted ALF case management.

WHO CAN PROVIDE MEDICAID-FUNDED ALF CASE MANAGEMENT?

Medicaid-funded case management services (either the annual reassessment or targeted ongoing case management) for ALF residents can be provided by staff of the following agencies who meet the knowledge, skills, and abilities (KSAs) of a case manager:

- Local departments of social services;
- Area agencies on aging;
- Centers for independent living;
- Community services boards;
- Local departments of health; and
- Private physicians who have a contract with DMAS to conduct assessments and who wish to follow clients on a continuing basis. Physicians who conduct assessments or reassessments or perform Medicaid-funded targeted case management may not have financial ties with the ALF.

Acute care hospitals, state mental health/mental retardation facilities, and correctional facilities may not complete the 12-month reassessment or provide Medicaid-funded targeted ALF case management. These groups may perform the initial assessments or assessments for changes in level of care only.

A case management agency must have signed an agreement with DMAS to be reimbursed for the provision of the annual reassessment only or the targeted case management services to AG recipients. The local department of social services serving the jurisdiction where the adult resides, following placement in an ALF, shall be the case management agency when there is no other qualified case management provider willing or able to provide case management services. The LDSS where the individual resides following ALF placement is responsible for the annual reassessment if no other assessor is willing or able to reassess the resident.

QUALIFICATIONS OF CASE MANAGEMENT PROVIDERS

To qualify as a provider of case management (i.e., either annual reassessment or targeted case management), the provider of services must ensure that claims are submitted for payment only when the services were performed by case managers meeting these qualifications. The case manager must possess a combination of work experience or relevant education that indicates that the individual possesses the following knowledge, skills, and abilities (KSAs). The case manager must have these knowledge, skills, and abilities at the entry level which must be documented or observable in the application form or supporting documentation or in the interview (with appropriate documentation).

1. Knowledge of:
 - a. Aging and the impact of disabilities and illnesses on aging;
 - b. Conducting assessments (including psychosocial, health, and functional factors) and their uses in care planning;
 - c. Interviewing techniques;
 - d. Consumers' rights;
 - e. Local human and health service delivery systems, including support services and public benefits eligibility requirements;
 - f. The principles of human behavior and interpersonal relationships;
 - g. Effective oral, written, and interpersonal communication principles and techniques;
 - h. General principles of record documentation; and
 - i. Service planning process and the major components of a service plan.
2. Skills in:
 - a. Negotiating with consumers and service providers;
 - b. Observing, recording, and reporting behaviors;
 - c. Identifying and documenting a consumer's needs for resources, services, and other assistance;
 - d. Identifying services within the established services system to meet the consumer's needs;
 - e. Coordinating the provision of services by diverse public and private providers; and
 - f. Analyzing and planning for the service needs of elderly persons.
3. Abilities to:
 - a. Demonstrate a positive regard for consumers and their families;
 - b. Be persistent and remain objective;
 - c. Work as a team member, maintaining effective inter- and intra-agency working relationships;
 - d. Work independently, performing position duties under general supervision;
 - e. Communicate effectively, verbally and in writing;
 - f. Develop a rapport and to communicate with different types of persons from diverse cultural backgrounds; and
 - g. Interview.

4. Individuals meeting all the above qualifications shall be considered a case manager; however, it is preferred that the case manager possess a minimum of an undergraduate degree in a human services field or be a licensed nurse. In addition, it is preferable that the case manager have two years of satisfactory experience in the human services field working with the elderly.

ANNUAL REASSESSMENT

The purpose of the annual reassessment is the reevaluation of service need and utilization review. The assessor or case manager shall review each resident's need for services annually, or more frequently as required, to ensure proper utilization of services. The outcome of this review shall be communicated to the LDSS eligibility staff, DMAS, the facility where the resident resides, and the resident. All ALF residents must be reassessed at least annually. All applicants for an AG must have an assessment completed before AG payment can be issued. See Chapter IV for further information on the annual reassessment.

If a resident is receiving targeted case management services for mental illness or mental retardation, the agency case manager for this service must complete the reassessment as part of case management responsibilities for that individual. DMAS will not reimburse the case management agency additionally for the completion of the assessment. This case management will be noted on the individual's UAI at the time of the initial assessment and the mental health case manager will be advised of the individual's authorization for ALF residence and the date when the reassessment is needed. The mental health case manager must complete the reassessment and follow the other directions for process of the annual reassessment.

ONGOING MEDICAID-FUNDED TARGETED ALF CASE MANAGEMENT SERVICES

Ongoing Medicaid-funded targeted ALF case management is a service provided to those public pay clients who are receiving residential or assisted living services and who:

1. Require coordination of multiple services and/or have some problem which must be addressed to ensure the resident's health and welfare; and
2. Are not able and do not have other support available to assist in coordination of and access to services or problem resolution; and
3. Need a level of coordination that is beyond what the ALF can reasonably be expected to provide.

The assessor should check "yes" on the DMAS-96 for ALF targeted case management ONLY when the individual is determined to need Medicaid-funded ongoing targeted case management services that have been specifically developed for ALF clients. "No" should be checked if the individual

will receive only the annual reassessment or may be receiving other types of Medicaid-funded case management services.

The assessor must authorize and arrange for case management services through a qualified case manager if such services are determined to be needed. It is the responsibility of the ALF to determine whether or not the facility is capable of providing the required coordination of services. Based upon information obtained from staff of the ALF where an individual may be placed, the assessor must determine whether the ALF can meet the care needs and whether ongoing case management is needed. The assessor must communicate with the ALF (such as by telephone) to identify service needs and to ensure that service needs can be met and, if placement is sought, forward a copy of the completed UAI to the potential ALF. Based upon information obtained, the assessor will determine whether the ALF can meet the care needs and whether ongoing case management is needed. The individual selects a case management agency of his or her choice in the area where he or she will reside. The assessor must be aware of available Medicaid-funded ALF targeted case management agencies and assist the individual in his or her selection.

Targeted ALF case management services are limited to AG eligible residents of ALFs who have needs beyond what the ALF can provide. AG eligibility and Medicaid eligibility may not be determined until after placement. Assessment and placement activities are already being provided by local public human services agencies or hospitals reimbursed through other funding sources, including the DMAS reimbursement for assessments.

For AG recipients, a case management agency must have signed an agreement with DMAS to be reimbursed for the provision of targeted case management services. (For private pay residents, fees are negotiated between the case manager and the resident, as any other purchased services would be.)

The case manager identifies care needs and assists in locating and arranging for services that are beyond the scope of the ALF services. The adult recipient chooses from the options made available by the case manager, and the case manager facilitates accessing the service provider. DMAS has the right to terminate the contract for assessment and case management for failure to follow DMAS requirements.

Ongoing targeted ALF case management must be terminated when the resident no longer requires these services.

CASE MANAGER RESPONSIBILITIES

The case manager for ongoing targeted ALF case management is responsible for:

1. The completion of the UAI, either short assessment or full assessment, as appropriate (the annual reassessment is considered one of the quarterly contacts; no additional reimbursement for reassessment beyond the quarterly reimbursement for case management will be made);

2. Any change in level of care, as appropriate;
3. Developing the plan of care that addresses needs on the UAI and maintaining the log of contacts and providing a copy of the care plan to the resident, the family, and the ALF. (See Appendix C for instructions and forms);
4. Implementing and monitoring the plan of care, including arranging, coordinating, and monitoring services;
5. Monitoring the ALF's Individualized Service Plan for the resident and other written communications concerning the care needs of the resident;
6. A quarterly visit with the resident or his or her representative to evaluate the resident's condition, service needs, appropriate service placement and satisfaction with care;
7. Serving as the contact for the ALF, family, and other service providers to coordinate and problem solve; and
8. Assistance with discharge, as necessary.

THE PLAN OF CARE

For purposes of Medicaid-funded ongoing targeted ALF case management, the plan of care (shown in Appendix C) is a standardized written description of the need(s) of the resident which cannot be met by the ALF and the case manager's strategy for arranging services to meet that need(s). The completion of the plan of care must include input from the individual, the family, and the ALF staff. The case manager determines which services must be provided to assure that the individual's health, safety, and welfare are protected.

The Plan of Care is different from the Individualized Service Plan (ISP). The ISP is the plan developed by the ALF staff that addresses the resident's needs and is required by VDSS Division of Licensing Programs standards.

The UAI Plan of Care is the form to be used by case managers authorizing ongoing case management services. The plan of care must be completed according to the type of service(s) being provided and must be resident-specific. The UAI Plan of Care is completed by the case manager and is different from the "Individualized Service Plan" completed by the ALF. While different, the two should complement each other. When Medicaid-funded targeted case management services are provided, the case manager must follow DMAS guidelines for preparing and implementing the care plan. The UAI Plan of Care addresses needs that cannot be met by the ALF.

Once the case manager has determined the individual's needs, the support available to meet those needs, and any other special considerations or concerns about the individual's environment or available support, the case manager may determine whether services provided in the ALF are a

viable option. The case manager must either contact the provider(s) chosen by the individual directly to discuss with the provider whether he or she will be able to meet the identified needs of the individual or confirm that this discussion has occurred between the individual/family/provider prior to sending the assessment package to the provider. If the individual indicates that any special arrangements or specific hours of care are needed, the case manager must either instruct the individual/family/provider to discuss these requirements to determine whether this provider can meet those special needs or the case manager can make that contact directly. Under no circumstances should the provider receive a referral from the case manager for an individual unless the case manager has confirmed that the provider is aware of the coming referral and can accept the individual for services.

Placement in an ALF should not be made for individuals requiring case management services unless the assessor can ensure that the appropriate services are available to the applicant/resident.

Case managers shall maintain a record of case management services provided to the ALF resident. The log shall list the date of all contacts between the case manager and the direct service providers, the ALF staff, and the resident. The log should summarize the nature of those contacts and cover services obtained for the resident, how the resident is responding, what unmet needs remain, and the progress that is being made toward securing still needed services. The log should also identify any changes in the resident's social, environmental, and medical circumstances.

OTHER MEDICAID-FUNDED CASE MANAGEMENT SERVICES

There are two other types of Medicaid-funded case management services that could potentially serve the residents of an ALF: case management services for the elderly and case management services for mental illness and mental retardation. DMAS will not reimburse for more than one type of Medicaid-funded case management service provided to an ALF resident.

Case Management Services for the Elderly

Case management services for the elderly focuses on community residents who do not live in an ALF. Targeted case management services are provided by local public human services agencies to assist Medicaid-eligible elderly individuals at highest risk of institutionalization to access services that support and encourage informal caregiving by coordinating the delivery of multiple services across multiple providers. This service was initiated within the context of the Case Management for Elderly Virginians Pilot Project. Case management services are reimbursed monthly on a fee for service basis and are authorized for a maximum six-month period.

Effective February 1, 1996, with the implementation of the Department of Social Services' ALF regulations, Case Management Services for the Elderly cannot be provided in an ALF.

Case Management Services for Mental Health/Mental Retardation

Case management services for mental health/mental retardation are a more intensive level of service than ALF case management. Case management services are a covered service under certain Medicaid programs. Services are restricted to specific populations based on the age and needs of the individual. Reimbursement for case management under the waiver is provided only for active case management consumers. Services must be provided frequently and timely as the person needs assistance from the assigned case manager. Services are provided for the duration of time needed as determined by the provider and the person on an individual basis. Case management staff are available to assigned persons when and where needed, including where the person resides or needs the services.

Case management services may not be billed for the same individual by any more than one type of case management provider. Therefore, an individual may not receive both mental health or mental retardation and targeted ALF case management services at the same time. If an individual receives targeted case management from either mental health or mental retardation services, and a need for services from another discipline is identified, one case manager must be identified as the primary case manager with billing occurring for that case manager only.

CHAPTER VI: REIMBURSEMENT PROCEDURES

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CONTRACTING WITH DMAS FOR REIMBURSEMENT

All assessors and case managers performing assessments or providing Medicaid-funded ALF case management services must have a contract with DMAS to receive reimbursement for services. DMAS will reimburse only for assessment and Medicaid-funded ALF case management of individuals who are public pay (i.e., AG recipients or applicants).

BECOMING A MEDICAID PROVIDER OF SERVICES

In order to become a Medicaid provider for ALF assessment and/or case management services, the provider must request a participation agreement by writing:

First Health Services/ VMAP-PEU
Post Office Box 26803
Richmond, VA 23261-6803
Telephone: 804-270-5105; Toll-free: 1-888-829-5373; Fax: 804-270-7027

Public human services agencies cannot perform assessment services without a DMAS provider agreement. In order to officially authorize DMAS services, the agency must have a provider agreement. This assessment process is covered under the current (Nursing Home Preadmission Screening) NHPAS agreements or interagency agreement for hospitals and local health departments already performing NHPAS.

ASSESSMENT PACKAGES

Each assessment package sent to DMAS for reimbursement is reviewed for accuracy, completeness, and adherence to DMAS policies and procedures. An incomplete, illegible, or inaccurate package will not be processed for payment. Reimbursement will be made only for an assessment which includes all the required forms that have been correctly completed and submitted and only for individuals who are eligible for an AG. The assessment package must be submitted to DMAS within 30 days of the assessment date to assure prompt reimbursement. There will be no reimbursement for assessments received by DMAS twelve months or more after the date of the completion of the assessment.

REIMBURSEMENT FOR INITIAL ASSESSMENTS AND CHANGES IN LEVEL OF CARE

The reimbursement process for initial assessments and changes in level of care are the same. When a recommendation is made that an individual meets ALF level of care, the assessor will document this decision on the UAI and the Long-Term Care Preadmission Screening Authorization (DMAS-96) and prepare an assessment package. The package is sent to:

First Health Services
P.O. Box 85083
Richmond, Virginia 23285-5083

The package for initial assessments and changes in level of care must include copies of:

- The DMAS-96
- The UAI, either short or long form as appropriate.

See Chapter II for procedures on the distribution of forms.

TIP: For initial assessments and changes in level of care, send to First Health Services:
1) *the DMAS-96,*
and
2) *the UAI.*

Initial assessments and changes in level of care assessments will be reimbursed by DMAS for AG recipients and applicants in the following amounts:

- \$100 for an initial full assessment;
- \$25 for an initial short assessment;
- \$100 for a change in level of care full assessment; and
- \$25 for change in level of care short assessment.

Assessors are advised to keep a log of assessments in order to ensure proper payments to their agencies or jurisdictions. Questions about reimbursements should be made in writing to:

Program Administration Supervisor
Facility- and Home-Based Services Unit
Department of Medical Assistance Services
600 East Broad Street
Richmond, Virginia 23219

Facility- and Home-Based Services Unit staff may be reached at 804-225-4222.

REIMBURSEMENT TO ASSESSORS FOR ANNUAL REASSESSMENTS

The reimbursement process for annual reassessments and ongoing targeted ALF case management are the same. Reimbursement for annual reassessments and targeted case management will be made by DMAS directly to the local assessment/case management agency.

Annual reassessments will be reimbursed by DMAS for AG recipients in the following amounts:

- \$25 for a short annual reassessment only.
- \$75 for a full annual reassessment only.

Payment for Medicaid-funded targeted ALF case management services cannot duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

The assessor will document his or her reassessment decision on the ALF Eligibility Communication Document and prepare the assessment package. The package is sent to:

First Health Services
P.O. Box 85083
Richmond, Virginia 23285-5083

The package for annual reassessments must include copies of:

- The UAI, either short or long form as appropriate.
- ALF Eligibility Communication Document.
- HCFA-1500.

TIP: For annual reassessments, send to First Health Services:

- 1) the UAI;*
- 2) Eligibility Communication Document; and*
- 3) The HCFA-1500.*

Please see Chapter IV for procedures on the distribution of forms following an annual reassessment or the provision of ongoing targeted ALF case management.

REIMBURSEMENT TO CASE MANAGERS FOR ONGOING TARGETED ALF CASE MANAGEMENT

Ongoing targeted ALF case management services will be reimbursed by DMAS for AG recipients in the following amount:

\$75 per quarter for ongoing Medicaid-funded targeted case management for AG recipients. (If ongoing case management is authorized, the reassessment is included in that reimbursement.)

Payment for Medicaid-funded targeted ALF case management services cannot duplicate payments made to public agencies or private entities under other program authorities for this same purpose. As such, the annual reassessment will be included in the reimbursement provided to case managers on a quarterly basis; no additional reimbursement for the annual reassessment will be made.

Public agencies may only receive reimbursement for Medicaid-funded targeted ALF case management services when the individual is shown to need such services and the agency has a provider agreement with DMAS. DMAS also provides Medicaid-funded targeted case management services for the elderly. These services cannot be provided to ALF residents.

Reimbursement for case management services is limited to no more than one payment per each calendar quarter. In order to bill for case management services during a calendar quarter, the case

manager must comply with the documentation requirements and have a documented on-site visit with the resident during that quarter.

When a recommendation is made that an individual meets ALF level of care, the assessor will document this decision on the UAI and the Long-Term Care Preadmission Screening Authorization (DMAS-96) and prepare an assessment package. The package is sent to:

First Health Services
P.O. Box 85083
Richmond, Virginia 23285-5083

In order to receive reimbursement for case management, the case management provider must have a signed DMAS provider agreement and provider number. The provider number must be used on the invoices submitted to DMAS for ongoing Medicaid-funded targeted ALF case management services. Payments for ongoing Medicaid-funded ALF targeted case management and twelve-month reassessments will be made directly to the assessor or case management agency based on the submission of an invoice to DMAS.

For ongoing targeted ALF case management services, the case manager **completes the HCFA-1500 only** and sends to DMAS. This completed billing invoice must be sent in order for the case manager to be reimbursed. See Appendix F for billing instructions. The case manager **will not send** the individual's plan(s) of care or the log that documents case management activity to DMAS. DMAS will review the required documentation during onsite visits to the ALF and the case management agencies. Copies of the individual's plan(s) of care should be provided to the ALF and the resident.

The HCFA-1500 is sent to:

Practitioner
Department of Medical Assistance Services
P.O. Box 27444
Richmond, VA 23261-7444

Please see Chapter IV for procedures on the distribution of forms following an annual reassessment or the provision of ongoing targeted ALF case management. See Exhibits 1-3 for sample reimbursement letters.

REIMBURSEMENT TO THE ALF

The ALF submits the admission package to DMAS, Long-Term Care Section, to receive approval to bill DMAS for the provision of assisted or intensive assisted living services*. The package includes a copy of the Individualized Service Plan and the DMAS-96. The resident receives the AG payment and pays the ALF for care provided, regardless of whether he or she is receiving residential, regular assisted, or intensive assisted living* level of services. The ALF bills DMAS on

the HCFA-1500 for the appropriate per diem rate (\$3 per day, up to \$90 per month for assisted living;).

**Only those residents who were assessed at the intensive assisted living level of care on or before March 17, 2000, are eligible for the IAL reimbursement add-on. DMAS will reimburse \$6 per day, up to \$180 per month for intensive assisted living.*

COMPLETING THE HCFA-1500

The HCFA-1500 (12-90), as shown at the end of this chapter), is a universally accepted claim form that is required when billing DMAS for such services as the annual reassessment and ongoing targeted ALF case management. The form is available from local business forms printers (check the *Yellow Pages* under “Business Forms and Systems”) and from the U.S. Government Printing Office, Washington, DC 20402, telephone number 1-202-512-1800.

The HCFA-1500 will not be provided by DMAS. **DMAS will NOT accept copies of the HCFA-1500; only original HCFA-1500 forms are acceptable.**

The following fields (locator numbers) **MUST** be completed for reimbursement:

- 1** Enter an “X” in the Medicaid box.
- 1a** **INSURED’S ID NUMBER.** Enter the 12-digit Virginia Medicaid number for the individual being assessed.
- 2** **PATIENT’S NAME.** Enter the name of the individual being assessed as it appears on the Medicaid identification: Last name, first name, and middle initial.
- 10** Complete **ONLY** if the individual’s condition is related to employment, an auto accident, or another type of accident. If yes, enter an “X” in the appropriate box. For ALF assessments, this will usually be left blank.
- 10d** Complete **ONLY** if an attachment is being sent with the claim form.
- 21** **DIAGNOSIS:** For ALF assessments, **LEAVE THIS FIELD BLANK.**
- 22** **MEDICAID RESUBMISSION:** Complete **ONLY** if a claim adjustment or void is being submitted.
- 24A** **DATES OF SERVICE:** Enter the “from” and “through” dates in a 2-digit format for the month, day, and year (e.g., 03/15/03-03/15/03). For ALF assessments, the from and through dates will be the same (i.e., the date of the assessment if both the from and through date). Do not cross over months; for services that extend for a longer period of time than a one-day assessment, the dates must be within the same calendar month.

24B PLACE OF SERVICE: For ALF assessments, always enter the 2-digit code “12” for resident’s home.

24C TYPE OF SERVICE: For ALF assessments, always enter the one-digit code “1” for medical care.

24D PROCEDURES, SERVICES, OR SUPPLIES: Enter one of the following 5-digit CPT/HCPCS codes as appropriate to the claim:

Z8574	Ongoing targeted ALF case management
Z8577	Annual reassessment, short form
Z8578	Annual reassessment, long form (full UAI)

MODIFIER: LEAVE BLANK unless billing for service dates greater than one year old. If the claim is over a year old, enter the 2-digit code “22” and attach an explanation about an unusual situation. Documentation is required if code “22” is entered.

24E DIAGNOSIS CODE: NOT REQUIRED.

24F CHARGES: Enter the charge requested for the reassessment or case management service (i.e., \$25 for a short UAI annual reassessment (code Z8577) and \$75 for the full UAI annual reassessment (code Z8578)). DMAS reimbursement for the annual reassessment, when it is performed during ongoing case management services, is \$75 (code Z8574).

24G DAYS OR UNITS: Enter the number of times the procedure, service, or item was provided during the service period. For ALF reassessments, enter “1” since the reassessment service is provided one time for the purpose of the claim. For case management, 1 unit = 1 quarter.

24I EMG (emergency): Enter a “1” if the service is an emergency. Leave blank if it is not an emergency.

24J COB (coordination of benefits): For ALF assessments, LEAVE BLANK since there is no other payment source.

24K RESERVED FOR LOCAL USE: LEAVE BLANK.

26 PATIENT’S ACCOUNT NUMBER: This item is OPTIONAL. Enter the resident’s account number if desired. Up to seventeen alpha-numeric characters are accepted.

31 SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES AND CREDENTIALS: Enter the signature of the assessor with degrees and credentials and the

date the assessment was completed. An individual designated by the assessment agency may sign the HCFA-1500 as well.

- 33 PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE, AND PHONE:** Enter the assessment agency's billing name, address, zip code, and telephone number as they appear in the Virginia Medicaid provider record. Enter the 7-digit Virginia Medicaid provider ED number in the PINN # field. Do not enter anything in the GRP # field.

ALL OTHER FIELDS ARE LEFT BLANK.

Adjustment of the HCFA-1500

The Adjustment Invoice is used to change information on a paid claim. Follow the instructions for the completion of the HCFA-1500 (12-90), except for the locator indicated below:

LOCATOR 22 Medicaid Resubmission

Code: Enter the 3-digit code identifying the reason for the submission of the adjustment invoice.

- 523 Primary carrier has made additional payment.
- 524 Primary carrier has denied payment.
- 525 Accommodation charge correction.
- 526 Patient payment amount changed.
- 527 Correcting service periods.
- 528 Correcting procedure/service code.
- 529 Correcting diagnosis code.
- 530 Correcting charges.
- 531 Correcting units/visits/studies/procedures.
- 532 IC reconsideration of allowance, documented.
- 533 Correcting admitting, referring, prescribing, provider identification number.

Void of the HCFA-1500

The Void Invoice is used to void a paid claim. Follow the instructions for the completion of the HCFA-1500 (12-90), except for the locator indicated below:

LOCATOR 22 Medicaid Resubmission

Code: Enter the 3-digit code identifying the reason for the submission of the void invoice.

- 542 Original claim has multiple incorrect items.
- 544 Wrong provider identification number.
- 545 Wrong recipient eligibility number.
- 546 Primary carrier has paid DMAS maximum allowance.
- 547 Duplicate payment was made.
- 548 Primary carrier has paid full charge.
- 551 Recipient not my patient.
- 552 Void is for miscellaneous reasons.
- 560 Other insurance available.

Adjustments and voids require the Original Reference Number in Locator 22. Enter the 9-digit claim reference number of the paid claim. This number may be obtained from the remittance voucher and required to identify the claim to the adjusted or voided invoice. Only one claim can be adjusted or voided on each HCFA-1500.

CHAPTER VII: INTENSIVE ASSISTED LIVING LEVEL OF CARE

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BACKGROUND

Prior to March 17, 2000, there were two levels of assisted living care in ALFs (regular assisted living and intensive assisted living) which were available to individuals who require assistance in activities of daily living and instrumental activities of daily living, which are above the room, board, and supervision provided by the ALF and as reimbursed by the AG program. The regular assisted living level was not part of this Medicaid waiver. The assessor responsible for completing the assessment and authorizing admissions to the ALF classified the individual into one of these two levels.

The Intensive Assisted Living (IAL) waiver in ALFs became effective August 1, 1996. This waiver provided Medicaid payment to assisted living providers who provide a variety of services to residents that meet the intensive assisted living criteria, including personal care and services, homemaker, chore, attendant care, companion services, medication oversight, therapeutic social and recreational programming provided in a home-like environment in a licensed ALF, in conjunction with residing in the facility. These services also included 24-hour on-site response staff to meet scheduled or unpredictable needs in a way that promotes maximum dignity and independence and provides supervision, safety, and security. Other individuals or agencies may also furnish care directly or under arrangement with the ALF, but the care provided by these other entities supplements that provided by the ALF and does not supplant it.

If licensed for assisted living, ALFs could opt to participate in DMAS' waiver program for intensive assisted living for AG recipients who met those criteria. To be reimbursed for intensive assisted living, ALFs needed to have a contract with DMAS to provide this level of care and must comply with DMAS' requirements for this waiver service. ALFs had to be licensed to provide assisted living before they could contract with DMAS to provide intensive assisted living services.

In March 2000, the Health Care Financing Administration did not renew Virginia's Intensive Assisted Living Waiver. The IAL Waiver is no longer available as a Medicaid-funded alternative to nursing facility placement, after March 17, 2000, for new applicants. There are now only two levels of care: residential care and assisted living.

Individuals who previously would have been assessed at the IAL level of care may still reside in an assisted living facility if all three of the following conditions are met:

- The individual does not have a prohibited condition;
- The ALF is licensed at the assisted living level; and
- The ALF is willing and able to meet all of the individual's care needs, including personal care and any mental health and/or mental retardation needs that may exist.

State funds are being used to supplement the federal share of the IAL payment for residents assessed at the IAL level of care on or before March 17, 2000. There can be no IAL payment for individuals assessed at this level after March 17, 2000. Documentation on the Virginia UAI should continue to clearly and accurately describe the care needs of the individual. DMAS is continuing to

conduct reviews of IAL recipients, and, as long as the ALF accepts the additional \$180 per month for “grandfathered” IAL residents, will expect to see the care provided in the IAL Waiver before it was not renewed. Only those residents who were assessed at the intensive assisted living level of care on or before March 17, 2000, are eligible for the intensive assisted living reimbursement add-on. DMAS will reimburse \$6 per day, up to \$180 per month for intensive assisted living.

DMAS will pay the ALF for services rendered while the individual is determined to be eligible for benefits under the AG program and authorized for assisted living care. The assisted living authorization is considered effective as of the date the Long-Term Care Preadmission Screening Authorization (DMAS-96) is signed and dated, except in the case of an emergency placement as defined in Chapter III, the assisted living authorization is considered effective as of the date of the emergency placement, provided that the Long-Term Care Preadmission Screening Authorization (DMAS-96) is signed and dated within seven working days after the date of the emergency placement.

In addition, in order for assisted living payments to be made to a facility, the assisted living authorization must be based on a UAI that complies with the requirements of *Code of Virginia*, § 63.2-1804. DMAS will continue to provide a per diem fee of \$3 for each individual authorized to receive assisted living services, based on which level of assisted living an individual requires.

CRITERIA FOR INTENSIVE ASSISTED LIVING IN AN ALF

Individuals meet the criteria for intensive assisted living as documented on the UAI when at least one of the following describes their capacity:

1. Rated dependent in four or more of seven ADLs (page 4 of UAI).
2. Rated dependent in two or more ADLs and rated as semi-dependent or dependent in a combination of behavior pattern (i.e., abusive, aggressive, or disruptive) and orientation (page 8 of UAI).
3. Rated semi-dependent in two or more ADLs and dependent in the combination behavior and orientation.

NURSING FACILITY CRITERIA

The differences between nursing facility criteria and intensive assisted living criteria are:

1. Identification of nursing needs is not required for an ALF resident with 4 ADLs; and
2. Medication administration, joint motion, and mobility are not factors considered in intensive assisted living.

The preadmission screening process preauthorizes a continuum of long-term care services available to an individual under the Virginia Medical Assistance Program. Medicaid-funded long-term care services may be provided in either a nursing facility or community-based care setting.

The criteria for assessing an individual's eligibility for Medicaid payment of nursing facility care consists of two components:

1. Functional capacity (the degree of assistance an individual requires to complete activities of daily living); and
2. Medical or nursing needs.

To qualify for Medicaid payment for nursing facility care, an individual must meet both functional capacity requirements and have a medical condition that requires ongoing medical or nursing management. An exception may be made when the individual does not meet the functional capacity requirement but the individual does have a health condition that requires the daily direct services of a licensed nurse that cannot be managed on an outpatient basis.

MEDICAID HOME- AND COMMUNITY-BASED SERVICES CRITERIA

The criteria for assessing an individual's eligibility for Medicaid payment of community-based care consist of three components:

1. Functional capacity (the degree of assistance an individual requires to complete activities of daily living);
2. Medical or nursing needs; and
3. The individual's risk of nursing facility placement in the absence of community-based waiver services.

To qualify for Medicaid payment for community-based care, an individual must either meet both the functional and medical components of the nursing facility criteria defined later in the section titled "Evaluation To Determine Eligibility For Medicaid Payment of Nursing Facility or Home and Community-Based Care Services." In addition, the individual must be determined to be at risk of nursing facility placement unless services under the waiver are offered.

Teams composed by agencies contracting with the Department of Medical Assistance Services (DMAS) perform preadmission screenings. The authorization for Medicaid-funded long-term care may be rescinded by the nursing facility or community-based care provider or by DMAS at any point that the individual is determined to no longer meet the criteria for Medicaid-funded long-term care. Medicaid-funded long-term care services are covered by the Program for individuals whose needs meet the criteria established by Program regulations. Authorization of appropriate noninstitutional services shall be evaluated before actual nursing facility placement is considered.

Prior to an individual's admission, the nursing facility must review the completed preadmission screening forms to ensure that appropriate nursing facility admission criteria have been documented.

The nursing facility is also responsible for documenting, upon admission and on an ongoing basis, that the individual meets and continues to meet nursing facility criteria. For this purpose, the nursing facility will use the Minimum Data Set (MDS). The post-admission assessment must be conducted no later than 14 days after the date of admission and promptly after a significant change in the resident's physical or mental condition. If at any time during the course of the resident's stay, it is determined that the resident does not meet nursing facility criteria as defined in the State Plan for Medical Assistance, the nursing facility must initiate the discharge of such resident. Nursing facilities must conduct a comprehensive, accurate, standardized, reproducible assessment of each resident's functional capacity and medical and nursing needs.

DMAS shall conduct surveys of the assessments completed by nursing facilities to determine that services provided to the residents meet nursing facility criteria and that needed services are provided. The community-based provider is responsible for documenting upon admission and on an ongoing basis that the individual meets the criteria for Medicaid-funded long-term care.

The criteria for nursing facility level of care under the Virginia Medical Assistance Program are contained herein. An individual's need for care must meet these criteria before authorization for payment by Medicaid will be made for either institutional or noninstitutional long-term care services. The Nursing Home Preadmission Screening Committee is responsible for documenting on the UAI that the individual meets the criteria for nursing facility or community-based waiver services and for authorizing admission to Medicaid-funded long-term care.

COMPLETING THE ELIBILITY COMMUNICATION DOCUMENT FOR IAL

Under the PURPOSE OF COMMUNICATION SECTION, check either 1., 2., or 3.

If 1. is checked (Annual Reassessment Completed), fill in the date of the reassessment. Check either a. (Resident continues to meet criteria for ALF placement at the following level of care) or b. (Resident does not meet criteria for residential or assisted living). If a. is checked, indicate which level of care the individual meets. If the resident being assessed is one of the "grandfathered" intensive assisted living placements who has been assessed at the intensive assisted living level of care, indicate in the space available that the resident "continues to need intensive assisted living services" and "based on the UAI, continues to meet criteria for intensive assisted living." When 1. is checked, the assessor sends a copy of the Uniform Assessment Instrument (UAI), the ALF Eligibility Communication Document (ECD), and the HCFA-1500 to DMAS. In addition, the assessor sends a copy of the ECD to the LDSS eligibility worker; copies of the UAI and ECD to the ALF; and a decision letter to the individual being assessed. The assessor should keep a copy of each of these documents.

APPENDIX A

ASSISTED LIVING FACILITY CRITERIA

ASSISTED LIVING FACILITY CRITERIA

AUTHORIZATION OF SERVICES TO BE PROVIDED

The assessor is responsible for authorizing the appropriate level of care for admission to and continued stay in an ALF. The ALF must also be knowledgeable of level of care criteria and is responsible for discharge of the resident whenever a resident does not meet the criteria for level of care in an ALF upon admission or at any later time. The appropriate level of care must be documented based on the completion of the Uniform Assessment Instrument (UAI) and definitions of activities of daily living and directions provided in the *User's Manual: Virginia Uniform Assessment Instrument*.

CRITERIA FOR RESIDENTIAL LIVING IN AN ALF

Individuals meet the criteria for residential living as documented on the UAI when at least one of the following describes their functional capacity:

1. Rated dependent in only one of seven ADLs (i.e., bathing, dressing, toileting, transferring, bowel function, bladder function, and eating/feeding); *OR*
2. Rated dependent in one or more of four selected IADLs (i.e., meal preparation, housekeeping, laundry, and money management): *OR*
3. Rated dependent in medication administration.

CRITERIA FOR ASSISTED LIVING IN AN ALF

Individuals meet the criteria for regular assisted living as documented on the UAI when at least one of the following describes their capacity:

1. Rated dependent in two or more of seven ADLs; *OR*
2. Rated dependent in behavior pattern (i.e., abusive, aggressive, and disruptive).

RATING OF LEVELS OF CARE ON THE UNIFORM ASSESSMENT INSTRUMENT

The rating of functional dependencies on the preadmission screening assessment instrument must be based on the individual's ability to function in a community environment, not including any institutionally induced dependence. Please see the *User's Manual: Virginia Uniform Assessment Instrument* for more detailed definitions.

The following abbreviations shall mean: I = independent; d = semi-dependent; D = dependent; MH = mechanical help; HH = human help.

(1) Bathing

- (a) Without help (**I**)
- (b) MH only (**d**)
- (c) HH only (**D**)
- (d) MH and HH (**D**)
- (e) Is bathed (**D**)

(2) Dressing

- (a) Without help (**I**)
- (b) MH only (**d**)
- (c) HH only (**D**)
- (d) MH and HH (**D**)
- (e) Is dressed (**D**)
- (f) Is not dressed (**D**)

(3) Toileting

- (a) Without help day or night **(I)**
- (b) MH only **(d)**
- (c) HH only **(D)**
- (d) MH and HH **(D)**
- (e) Does not use toilet room **(D)**

(5) Bowel Function

- (a) Continent **(I)**
- (b) Incontinent less than weekly **(d)**
- (c) Ostomy self-care **(d)**
- (d) Incontinent weekly or more **(D)**
- (e) Ostomy not self-care **(D)**

(4) Transferring

- (a) Without help **(I)**
- (b) MH only **(d)**
- (c) HH only **(D)**
- (d) MH and HH **(D)**
- (e) Is transferred **(D)**
- (f) Is not transferred **(D)**

(6) Bladder Function

- (a) Continent **(I)**
- (b) Incontinent less than weekly **(d)**
- (c) External device self-care **(d)**
- (d) Indwelling catheter self-care **(d)**
- (e) Ostomy self-care **(d)**
- (f) Incontinent weekly or more **(D)**
- (g) External device, not self-care **(D)**
- (h) Indwelling catheter, not self-care **(D)**
- (i) Ostomy not self-care **(D)**

(7) Eating/Feeding

- (a) Without help **(I)**
- (b) MH only **(d)**
- (c) HH only **(D)**
- (d) MH and HH **(D)**
- (e) Spoon fed **(D)**
- (f) Syringe or tube fed **(D)**
- (g) Fed by IV or clysis **(D)**

(9) Joint Motion (NF)

- (a) Within normal limits **(I)**
- (b) Limited motion **(d)**
- (c) Instability corrected **(I)**
- (d) Instability uncorrected **(D)**
- (e) Immobility **(D)**

(10) Mobility

- (a) Goes outside without help **(I)**
- (b) Goes outside MH only **(d)**
- (c) Goes outside HH only **(D)**
- (d) Goes outside MH and HH **(D)**
- (e) Confined moves about **(D)**
- (f) Confined does not move about **(D)**

(8) Behavior Pattern and Orientation

- (a) Appropriate or than Wandering/Passive less weekly + Oriented **(I)**
- (b) Appropriate or Wandering/Passive < weekly + Disoriented Some Spheres **(I)**
- (c) Wandering/Passive Weekly/or more + Oriented **(I)**
- (d) Appropriate or Wandering/Passive < weekly + Disoriented All Spheres **(d)**
- (e) Wandering/Passive Weekly or more + Disoriented Some or All Spheres **(d)**
- (f) Abusive/Aggressive/Disruptive < weekly + Oriented or Disoriented **(d)**
- (g) Abusive/Aggressive/Disruptive weekly or more + Oriented **(d)**
- (h) Abusive/Aggressive/Disruptive weekly or more + Disoriented **(D)**

(11) Medication Administration (NF)

- (a) No medications **(I)**
- (b) Self-administered, monitored < weekly **(I)**
- (c) By lay persons, monitored < weekly **(I)**
- (d) By Licensed/Professional nurse and/or monitored weekly or more **(d)**
- (e) Some or all by Professional nurse **(D)**

(12) Medication Administration (ALF)

- (a) Without assistance **(I)**
- (b) Administered, monitored by lay person **(D)**
- (c) Administered, monitored by professional staff **(D)**

(13) Behavior Pattern

- (a) Appropriate **(I)**
- (b) Wandering/passive less than weekly **(I)**
- (c) Wandering/passive weekly or more **(d)**
- (d) Abusive/aggressive/disruptive less than weekly **(D)**
- (e) Abusive/aggressive/disruptive weekly or more **(D)**

(14) Instrumental Activities of Daily Living (ALF)

- (a) Meal Preparation
 - (1) No help needed
 - (2) Needs help **(D)**
- (b) Housekeeping
 - (1) No help needed
 - (2) Needs help **(D)**
- (c) Laundry
 - (1) No help needed
 - (2) Needs help **(D)**
- (d) Money Management
 - (1) No help needed
 - (2) Needs help **(D)**

For more detailed descriptions of each of the above, please refer to the *User's Manual: Virginia Uniform Assessment Instrument* (April 1998).

BATHING

Bathing is the process of washing the body or body parts, including getting to or obtaining the bathing water and/or equipment whether this is in the bed, shower, or tub.

- Bathes without Help means the individual usually completes the entire bathing process unaided, or receives help to bathe one body part only.
- Bathes with Mechanical Help Only means the individual usually uses equipment or a device to complete the bathing process. Equipment or device includes shower/tub chair, grabrails, pedal/knee controlled faucet, long-handled brush, and mechanical lift.
- Bathes with Human Help Only means the individual usually receives assistance from another person(s) who may bring water/equipment, bathe some body parts, fill the tub with water, towel dry, observe, supervise, or teach the individual to bathe self.
- Bathes with Mechanical and Human Help means the individual usually uses equipment or a device and receives the assistance of another person.
- Is Bathed means the individual is completely bathed by another person(s) and does not participate in the activity.
- Does Not Bathe means the individual does not perform the bathing process, and it is not performed by another person.

The type of mechanical help and/or the number of human assistants used are specified in the spaces provided.

DRESSING

Dressing is the process of putting on, fastening, and taking off all items of clothing, braces and artificial limbs that are worn daily by the individual including obtaining and replacing the items from their storage area in the immediate environment. Clothing refers to the clothing usually worn daily by the individual. Individuals who wear pajamas or a gown with robe and slippers as their usual attire are considered dressed.

- Dresses without Help means the individual usually completes the dressing process unaided, or receives help in tying shoes only.
- Dresses with Mechanical Help Only means the individual usually uses equipment or a device to complete the dressing process. Equipment or device may include long-handled shoehorn, zipper pulls, velcro fasteners, adapted clothing, and walker with attached basket or other device to obtain clothing.
- Dresses with Human Help Only means the individual usually receives assistance from another person(s) who helps the individual in obtaining clothing; fastening hooks; putting on clothes, braces, artificial limbs; observes, supervises, or teaches the individual to dress self.
- Dresses with Mechanical and Human Help means the individual usually uses equipment or a device and receives the assistance of another person(s) to dress.
- Is Dressed means the individual is completely dressed by another person.
- Is Not Dressed refers only to bedfast individuals who are considered not dressed.

The type of mechanical help and/or number of human assistants used are specified in the spaces provided.

TOILETING

Toileting is the process of getting to and from the toilet room for elimination of feces and urine, transferring on and off the toilet, cleaning self after elimination, and adjusting clothes. A commode in any location may be considered the "toilet room" only if in addition to meeting the criteria for "toileting," the individual empties, cleanses, and replaces the receptacle without assistance from another person(s).

- Uses Toilet Room without Help Day and Night means the individual usually uses only the toilet room for elimination.
- Uses Toilet Room with Mechanical Help Only means the individual usually uses equipment or a device to get into or out of the toilet room, or other device to complete the toileting process. Equipment or device may include raised toilet or seat, handrails, wheelchair, walker, cane or transfer board. The individual who toilets without help during the day but uses a bedpan, urinal, or commode without human help to toilet during the night is considered to be toileting without help.
- Uses Toilet Room with Human Help Only means the individual usually receives assistance from another person(s) to complete the toileting process. Help from another person(s) means another person(s) helps the individual in getting to and from the toilet room, adjusting clothes, transferring on and off the toilet, or cleaning after elimination.
- Uses Toilet Room with Mechanical and Human Help means the individual usually uses equipment or a device and receives the assistance of another person(s).
- Does Not Use Toilet Room means the individual usually uses a bedpan, urinal, or commode for elimination or is incontinent and does not use the toilet room.

The type of mechanical help and/or number of human assistants used are specified in the space provided.

TRANSFERRING

Transferring is the process of moving horizontally and/or vertically between the bed, chair, wheelchair, and/or stretcher.

- Transfers without Help means the individual usually completes the transferring process unaided.
- Transfers with Mechanical Help Only means the individual usually uses equipment or a device to transfer. Equipment or device includes: sliding board, overhead pulley, trapeze, special bed, railing on bed, tub, toilet, walker, or the arm of a chair, etc.
- Transfers with Human Help Only means the individual usually receives the assistance of another person(s) lifting some of the individual's body weight, guarding, guiding, protecting, or supervising in the process of transferring.
- Transfers with Mechanical and Human Help means the individual usually uses mechanical equipment or a device and receives assistance from another person(s). The individual who bears weight on at least one arm or is considered to be participating in transferring.

- Is Transferred means the individual usually is lifted out of bed, chair, etc., by another person(s) and does not participate in the process. If the individual does not bear weight on any body part in the transferring process she or he is not participating in transferring. This category may also include the use of equipment or devices such as a mechanical lift, Hoyer lift, etc.
- Is Not Transferred means the individual is confined to bed.

The type of mechanical help and/or number of human assistants used are specified in space provided.

BOWEL FUNCTION

Bowel Function is the physiological process of elimination of feces from the bowel.

- Continent means the individual voluntarily controls the evacuation of feces from his or her bowels.
- Incontinent means the individual has involuntary evacuation of feces from his or her bowels.
- Ostomy is a surgical procedure that establishes an artificial anus by an opening into the colon (colostomy) or ileum (ileostomy).
- Self-Care means that the individual completely cares for his or her ostomy.
- Not Self-Care means that another person(s) cares for the individual's ostomy: stoma and skin cleaning, dressing, application of appliance, irrigations, etc.

The type of ostomy or other bowel problem; e.g., constipation, is specified in the space provided.

BLADDER FUNCTION

Bladder Function is the physiological process of elimination of urine from the bladder.

- Continent means the individual voluntarily empties his or her bladder.
- Incontinent means the individual has involuntary emptying or loss of urine.
- External Device is a urosheath or condom drainage apparatus with a receptacle attached to collect urine.
- Indwelling Catheter is a hollow cylinder passed through the urethra into the bladder and retained there to keep the bladder drained of urine.
- Ostomy is a surgical procedure that establishes an external opening into the ureter(s).
 - Self-Care means the individual completely cares for the skin surrounding the ostomy and for urinary devices; e.g., changes the catheter or external device, irrigates as needed, and empties and replaces the receptacle.
 - Not Self-Care means another person(s) cares for the individual's ostomy or urinary devices.

The type of ostomy or other urinary problem; e.g., retention, is specified in the space provided.

EATING/FEEDING

Eating/Feeding is the process of getting food by any means from the receptacle (plate, cup, glass, bottle, etc.) into the body. This item describes the process of eating after food is placed in front of an individual.

- Feeds Self without Help means the individual usually eats unaided.
- Feeds Self with Mechanical Help Only means the individual usually uses equipment or a device to eat. Equipment or device includes adapted utensils, plate guard, hand splint, suction dishes or nonskid plates, etc.
- Feeds Self with Human Help Only means the individual usually receives the assistance of another person(s) to bring food to the mouth, cut meat, butter bread, open cartons, or pour liquids. Mechanically adjusted diets such as ground, pureed, soft, etc., are not considered help.
- Feeds Self with Mechanical and Human Help means the individual usually uses equipment or a device and receives the help of another person(s).
- Is Spoon Fed means the individual usually does not bring any food to his or her mouth and is fed completely by another person(s).
- Fed via Syringe or Tube means the individual usually is fed a prescribed liquid diet via a naso-oral gavage or gastrogavage tube.
- Fed by I.V. or Clysis means the individual usually is fed a prescribed sterile solution intravenously or by clysis.

The type of mechanical and/or human help used, or additional information about syringe, tube, I.V., or clysis feedings is specified in the spaces provided.

BEHAVIOR PATTERN

Behavior Pattern is the manner of conducting oneself within one's environment.

- Appropriate means the individual's behavior pattern is suitable or fitting to the environment. Appropriate behavior is of the type that adjusts to accommodate expectations in different environments and social circumstances. Behavior pattern does not refer to personality characteristics such as "selfish," "impatient," or "demanding," but is based on direct observations of the individual's actions.
- Inappropriate Wandering, Passive, or Other means the individual's usual behavior is manifested in a way that does not present major management problems. Wandering is characterized by physically moving about aimlessly or mentally being non-focused. Passive behavior is characterized by a lack of awareness or interest in personal matters and/or in activities taking place in close proximity. Other characterizations of behavior such as impaired judgment, regressive behavior, agitation or hallucinations that is not disruptive are included in this category and specified in the space provided.

- Inappropriate Abusive, Aggressive, or Disruptive means the individual's behavior is manifested by acts detrimental to the life, comfort, safety, and/or property of the individual and/or others. Agitations, hallucinations, or assaultive behavior that is detrimental are included in this category and specified in the space provided.
- Comatose refers to the semi-conscious state.

The type of inappropriate behavior is specified in the space provided. I refers to independence of the individual in behavior management.

ORIENTATION

Orientation is the awareness of an individual within his or her environment in relation to time, place and person.

- Oriented means the individual is aware of who he or she is, where he or she is and what time, day, month or year it is.
- Disoriented-Some Spheres, Sometime means the individual is disoriented in one or two spheres, time only or time and place, some of the time. Some of the time refers to alternating periods of awareness-unawareness.
- Disoriented-All Spheres, All Time means the individual is disoriented in one or two spheres, time only or time and place, and this is the individual's usual state.
- Disoriented-All Spheres, Sometime means the individual is disoriented to time, place and person (all three spheres) some of the time.
- Disoriented-All Spheres, All Time means the individual is always unaware of time, place and his or her identity.
- Comatose refers to the semi-conscious or unconscious state.

The spheres to which the individual is disoriented are specified in the space provided. I refers to independent; the individual is oriented.

MEDICATION ADMINISTRATION

Medication Administration refers to the person(s) who administer medications or if the individual is being referred elsewhere, the person(s) who will administer medications following referral.

- No Medications means the individual does not receive oral or injectable medications.
- Self-Administered, Monitored Less Often Than Weekly means the individual takes (or will take) medications without assistance and the effects of drug taking are (to be) observed by licensed or professional health personnel less often than weekly.
- Administered by a Lay Person, Monitored Less Often Than Weekly means a person without pharmacology training gives (or will give) the individual all of the prescribed medications or gives some of them and the remaining medications are (to be) self-administered. Monitoring the effects of drug taking are (to be) observed by licensed or professional health personnel less often than weekly.

- Administered by Licensed or Professional Health Personnel and/or Monitored Weekly or More Often means licensed or professional health personnel administer (or will administer) some or all of the individual's medications. Other medications may be self-administered or given by a person(s) without pharmacology training. The effects of drug taking are (to be) monitored weekly or more often by licensed or professional health personnel.
- Administered by a Professional means a health professional with additional special training administers (or will administer) and/or monitors specific medications; e.g., IV.s, potent experimental drugs, etc. Other medications are (will be) administered by licensed or professional health personnel, lay person(s) or self-administered.

APPENDIX B

ALF ASSESSMENT

OVERVIEW

ASSISTED LIVING FACILITY ASSESSMENT OVERVIEW

When to Complete a Virginia Uniform Assessment Instrument (UAI)

- Within 90 days prior to the date of admission to the assisted living facility (ALF).
- At least once every 12 months on all ALF residents. The 12-month reassessment is based upon the date of the last assessment, whether it was the original, a reassessment, or change in level of care.
- Whenever there is a change in the resident's condition that appears to warrant a change in level of care.

Initial Assessments and Changes in Level of Care

For initial assessments and changes in level of care, send the following information to First Health Services, P.O. Box 85083, Richmond, VA 23285-5083:

- The DMAS-96; and
- The UAI, either short or long form, as appropriate. The short form consists of the first four pages of the UAI plus questions on behavior pattern (section on page 8 of UAI, "Behavior Pattern") and medication administration (section on page 5 of the UAI, "How do you take your medication?"). The long form is the entire UAI.

In addition, the assessor distributes the following:

- To the LDSS eligibility worker (locality is based on where the individual lived prior to placement in a facility), send a copy of the DMAS-96.
- To the admitting ALF, send the original UAI, DMAS-96, and the decision letter.
- To the individual being assessed, send a decision letter (see Appendix B of DMAS manual).
- The assessor keeps copies of the UAI, DMAS-96, consent form, and decision letter.

Twelve-Month Reassessments

For 12-month reassessments, send the following information to First Health Services:

- ALF Eligibility Communication Document;
- The UAI, either short or long form, as appropriate; and
- The HCFA-1500.

In addition, the assessor distributes the following:

To the LDSS eligibility worker (locality is based on where the individual lived prior to placement in a facility), send a copy of the ALF Eligibility Communication Document.

- To the admitting ALF, send the original UAI and the Eligibility Communication Document.
- To the individual being assessed, send a decision letter.
- The assessor keeps copies of the UAI, HCFA-1500, decision letter, and the Eligibility Communication Document.

NOTE: *If a reassessment becomes a change in level of care, treat as a change in level of care.*

Reimbursement for Initial Assessments and Changes in Level of Care

For VDSS assessments, DMAS will reimburse the state agency through an interagency transfer of funds; these reimbursements for ALF initial assessments completed by local departments of social services are handled in the same manner as NHPAS. For all other public agency assessors, DMAS will reimburse directly to the agency.

Reimbursement for 12-month Reassessments and Case Management

DMAS will reimburse the assessment entity directly based on the submission of the HCFA-1500. Use the following z-codes on the HCFA-1500:

Z8574 ALF case management
 Z8577 Annual short ALF assessment
 Z8578 Annual full ALF assessment

Reimbursement Rates:

Initial Assessment, short UAI:	\$25
Initial Assessment, full UAI:	\$100
Change in Level of Care:	\$25 for short UAI or \$100 for full UAI
Reassessment, short UAI:	\$25
Reassessment, full UAI:	\$75
Case Management:	\$75/quarter

APPENDIX C

FORMS

FORMS USED IN THE ASSISTED LIVING FACILITY (ALF) ASSESSMENT PROCESS

FORMS

Virginia Uniform Assessment Instrument (UAI)

Use to assess public pay (i.e., Auxiliary Grant) applicants to and residents of an ALF. Two versions exist: the short form, which is used to assess individuals requiring residential living and the full assessment that is used to assess individuals requiring assisted living.

Medicaid-Funded Long-Term Care Preadmission Screening Authorization (DMAS-96)

Use at *initial assessment and when there is a change in level of care*. Must be sent to DMAS in order to receive reimbursement for assessment.

HCFA-1500

Billing invoice used to request reimbursement from DMAS for annual reassessment and ongoing targeted ALF case management.

Worksheet to Determine ALF Level of Care (Use of this form is optional.)

Use to tally results of UAI assessment to quickly determine an individual's level of care.

Assisted Living Facility Eligibility Communication Form

Use to notify local department of social services eligibility worker and DMAS of annual reassessment.

UAI Plan of Care

Used by case manager to develop plan of care based on completed UAI for ALF residents receiving ongoing Medicaid-funded targeted case management.

Virginia UAI Add-on Page (Use of this form is optional.)

One paged assessment to be used with the short form of the UAI to answer questions on medication administration from page 5 of the full UAI and behavior pattern and orientation from page 8 of the UAI.

Interagency Consent to Release Confidential Information about Alcohol and Drug Patients

Consent to Release Information

With the exception of the HCFA-1500, plain paper copies of these forms are acceptable.

WHERE TO GET FORMS

Forms Available from the Department of Medical Assistance Services (DMAS)

DMAS provides access to provider forms via:

- The DMAS web site <http://www.cns.state.va.us/dmas/>
- Form copies in Medicaid provider manuals
- The DMAS Order Desk at 804-780-0076; callers will be sent ONE original form to be copied as needed.

Forms available from DMAS include the *User's Manual: Virginia Uniform Assessment Instrument*, DMAS-96, and the *Virginia UAI*.

Forms Available from VDSS

The following forms and manuals are available from the Virginia Department of Social Services, Adult Services Programs, 730 East Broad Street, Richmond, VA 23219; telephone: 804-692-1299. *Assisted Living Facility Assessment Manual*.

- *ALF Eligibility Communication Document* (plain paper copies are acceptable).
- *ALF Worksheet to Determine ALF Level of Care* (optional form).
- *User's Manual: Virginia Uniform Assessment Instrument (UAI) for Private Pay Residents of Assisted Living Facilities*.
- *Virginia Uniform Assessment Instrument (UAI) for Private Pay Residents*.

VDSS provides access to forms via:

- The VDSS web site <http://www.dss.state.va.us/>. Go to Adult Services forms.
- By calling 804-692-1299; callers will be sent ONE original either by mail or electronically (when available) to be copied as needed.

Forms Available from Other Sources

HCFA-1500

The HCFA-1500 (12-90) is a universally accepted claim form that is required when billing DMAS for such services as case management. The form is available from the U.S. Government Printing Office (telephone number 202-512-2457) and from business forms printers (consult your local *Yellow Pages* under "Business Forms" for vendors). The HCFA-1500 (12-90) will not be provided by DMAS. Only original forms (no photocopies) will be accepted.

UAI1

UAI2

UAI3

UAI4

UAI5

UAI6

UAI7

UAI8

UAI9

UAI10

UAI11

UAI12

DMAS-96

DMAS96 Instructions

HCFA1500

WORKSHEET TO DETERMINE ALF LEVEL OF CARE

(The use of this worksheet is optional.)

Resident's Name: _____

STEP 1: Based on the completed UAI, complete sections below.

ADLs	Check if Dependent (D)
Bathing	
Dressing	
Toileting	
Transferring	
Eating/Feeding	
Bowel	
Bladder	

Selected IADLs	Check if Dependent (D)
Meal Preparation	
Housekeeping	
Laundry	
Money Management	

Number of ADL Dependencies: _____

Number of IADL Dependencies: _____

Medication Administration: Check here if Dependent _____

Behavior Pattern: Check here if Dependent _____

Behavior Pattern and Orientation: Check here if
Semi-Dependent or Dependent _____

The resident has no prohibited conditions per the
Code of Virginia, § 63.2-1805. _____

STEP 2: Apply the above responses to the criteria below to determine where the individual fits and circle the appropriate level of care.

RESIDENTIAL LIVING LEVEL OF CARE IN AN ALF:

1. Rated dependent in only one of seven ADLs; OR
2. Rated dependent in one or more of four selected IADLs; OR
3. Rated dependent in medication administration.

REGULAR ASSISTED LIVING LEVEL OF CARE IN AN ALF:

1. Rated dependent in two or more of seven ADLs; OR
2. Rated dependent in behavior pattern.

**VIRGINIA DEPARTMENTS OF MEDICAL ASSISTANCE SERVICES/
SOCIAL SERVICES ASSISTED LIVING FACILITY
ELIGIBILITY COMMUNICATION DOCUMENT**

To/From: Dept. of Social Services Eligibility Worker in _____
(City/County Responsible for Auxiliary Grant)

Address: _____

To/From: _____
(ALF Assessor/Case Manager)

Address: _____

Assessor's provider #: _____

RESIDENT: _____ **SSN:** _____

ALF and Location: _____

Medicaid #: _____

PURPOSE OF COMMUNICATION (check 1, 2, or 3):

- ___ **1. ANNUAL REASSESSMENT COMPLETED ; Date of Reassessment:** ____/____/____
a. ___ **Resident Continues to Meet Criteria for ALF Placement at the following level of care:**
____ Residential Living ____ Assisted Living
b. ___ **Resident Does Not Meet Criteria for Residential or Assisted Living**

- ___ **2. RESIDENT NO LONGER RESIDES IN ALF ON RECORD.** Resident has been discharged to:

- a. ___ **Another ALF.** Last Date of Service in the ALF on Record: ____/____/____

Name of New ALF : _____

Provider #: _____ Start of Care Date in New ALF: ____/____/____

Address of New ALF: _____

- b. ___ **Home.** Last Date of Service in the ALF: ____/____/____

New Address: _____

- c. ___ **Other** (please specify): _____

Last Date of Service in the ALF: ____/____/____

New address: _____

- ___ **3. AUXILIARY GRANT ELIGIBILITY TERMINATED** Effective Date: ____/____/____

Reason: _____

(Name of Assessor/Case Manager Completing Form)		(Name of Eligibility Worker Completing Form)	
(Signature of Assessor/Case Manager Completing Form)		(Signature of Eligibility Worker Completing Form)	
(Date)	(Telephone No.)	(Date)	(Telephone No.)

ALF ELIGIBILITY COMMUNICATION DOCUMENT INSTRUCTIONS

WHEN TO USE THIS FORM

This form is a communication tool between the local department of social services (LDSS) eligibility worker, the assessor/case manager responsible for the 12-month reassessment of the assisted living facility (ALF) resident, and DMAS. This form is completed by:

1. The assessor to the eligibility worker and to DMAS at the time of a 12-month reassessment (a finding that the resident continues to meet either residential or assisted living is required in order for the eligibility worker to redetermine eligibility for an Auxiliary Grant (AG) payment);
 2. Either the assessor or eligibility worker to the other and to DMAS whenever either becomes aware of a change in address; and
 3. The eligibility worker to the ALF assessor and to DMAS whenever the AG is terminated.
-

TO/FROM SECTION

Both TO/FROM sections must be completed. Completely fill in the locality of the DSS eligibility worker with address and indicate whether document is to be sent to or from the eligibility worker by circling "TO" or "FROM." In the second TO/FROM section, completely fill in the assessor's name, address and provider number and indicate whether the document is to be sent to or from the assessor or case manager by circling "TO" or "FROM."

RESIDENT IDENTIFICATION SECTION

1. RESIDENT: Legibly print name of ALF resident who is being assessed, who has moved, or whose AG has been terminated.
 2. SSN: Write in the resident's social security number.
 3. ALF: Legibly print the name of the ALF in which the resident resides.
 4. ALF location: List the city/town in which the ALF is located.
 5. Medicaid Number: Write in the resident's Medicaid number.
-

PURPOSE OF COMMUNICATION SECTION: Check either 1., 2., or 3.

If 1. is checked (Annual Reassessment Completed), fill in the date of the reassessment. Check either a. (Resident continues to meet criteria for ALF placement at the following level of care) or b. (Resident does not meet criteria for residential or assisted living. If a. is checked, indicate which level of care the individual meets. If intensive assisted living is checked, respond to the two questions "continues to need intensive assisted living services" and "based on the UAI, continues to meet criteria for intensive assisted living." Usually, both will be checked "yes." When 1. is checked, the assessor sends a copy of the Uniform Assessment Instrument (UAI), the ALF Eligibility Communication Document (ECD), and the HCFA-1500 to DMAS. In addition, the assessor sends a copy of the ECD to the LDSS eligibility worker; copies of the UAI and ECD to the ALF; and a decision letter to the individual being assessed. The assessor should keep a copy of each of these documents.

NOTE: If a reassessment indicates a change in level of care, treat the assessment as a change in level of care. That is, send a copy of the UAI and the DMAS-96 to DMAS. In addition, send the

eligibility worker a copy of the DMAS-96; send to the ALF copies of the UAI, DMAS-96, and decision letter; and send a decision letter to the individual being assessed. The assessor should keep a copy of each.

If 2. is checked (Resident no longer resides in ALF on record), indicate to where the resident moved (i.e., another ACR, home, or other). For each, indicate the last date of service in the ALF on record. Complete other information such as new address, etc., if known. When 2. is checked, the assessor/case manager or eligibility worker completing the ECD should send a copy to the other and a copy to DMAS and keep a copy for him- or herself.

If 3. is checked (Auxiliary Grant Eligibility Terminated), the eligibility worker indicates the effective date of termination and the reason. Then the eligibility worker sends a copy of the ECD to the assessor/case manager and to DMAS.

SIGNATURES SECTION

For each form completed, only one signature section will be completed. For example, if an assessor is completing the form for a reassessment, the left-hand side with assessor information will be completed. If the eligibility worker is completing the form for notification of AG eligibility termination, then the right-hand side is completed. Please completely fill in the applicable section with printed name of individual completing the form, signature, complete date with month/day/year, and telephone number with area code.

Please photocopy this form as needed; plain paper copies are acceptable.

UAI/PLAN OF CARE

Client Name: _____ Social Security # _____
Medicaid # _____

Provider Name: _____ Provider ID# _____
Provider Phone # _____

Case Management Initiated: _____ Medicaid Eligibility Approved: _____
(Date) (Date-if after date initiated)

MEDICAID CLIENTS ONLY:

Initial Authorization: _____ Reauthorization: _____
(Must submit to DMAS prior to billing) (Must request 2 weeks prior to end date)

GOALS: Circle one or more.

1. To assist client to remain in his/her own home/ALF with supports as necessary.
2. To assist client in attaining and maintaining appropriate independent functioning based on his/her capabilities.
3. To assist in arranging out-of-home placements as appropriate with either client/legal representative's consent or court orders.
4. Short-term assistance to access services.

Other goals: _____

Client Name: _____
Social Security # _____ Medicaid # _____

UNMET NEED FROM UAI SUMMARY	MEASURABLE OBJECTIVE TO MEET IDENTIFIED NEED	TASK(S) TO BE DONE TO MEET OBJECTIVE	EXPECTED TIME FRAME	DATE RESOLVED

UNMET NEED FROM UAI SUMMARY	MEASURABLE OBJECTIVE TO MEET IDENTIFIED NEED	TASK(S) TO BE DONE TO MEET OBJECTIVE	EXPECTED TIME FRAME	DATE RESOLVED

SIGNATURES: _____
 Recipient of Services/Date **Case Manager/Date**

Case Manager Comments:

Enrolled by DMAS: Services Effective_____ **Thru End Date**_____ **DMAS Analyst**_____
Date Enrolled_____

ASSISTED LIVING FACILITY CASE MANAGEMENT SERVICES PROGRESS LOG

RESIDENT NAME: _____ MEDICAID ID#: _____
PROVIDER #: _____

DATE	ACTION TAKEN	RESULTS OF ACTION TAKEN

CASE MANAGER'S SIGNATURE: _____ DATE: _____

ASSISTED LIVING FACILITY CASE MANAGEMENT PLAN OF CARE INSTRUCTIONS

Care plan means a standardized, written description of the need(s) which cannot be met the assisted living facility (ALF) and the case manager's strategy for arranging services to meet that need(s). Care planning is the core of case management, and it is based on the information gathered during the assessment. The process of care planning includes (1) reviewing the assessment data; (2) using professional knowledge to determine available resources; (3) discussing options with the client, involved informal providers, and the ALF staff; (4) writing the care plan; and (5) explaining and discussing it with the client and applicable caregivers. Specific components of the care plan developed for use with the Uniform Assessment Instrument (UAI) are discussed below.

Identifying Information: Record the client's name, social security number, Medicaid number, the name of the provider (the agency where the case manager developing the care plan works), the provider ID number (Medicaid provider # for the case management agency), and the provider phone number. In the next spaces, record the date case management started and the date Medicaid eligibility was approved. Only record the eligibility approval date if it is after the date case management started. Leave this space blank for non-Medicaid clients and/or clients who were Medicaid eligible before the initiation of case management.

Goals: These represent overall goals of case management. Circle all that apply. There is also space to write in other goals specific to the client's situation. Goals represent the outcomes of case management and should guide the length of case management services. In other words, when the case manager and client feel these goals have been met, consideration should be given to closing the client's case to ongoing ALF case management services.

Unmet Need from UAI Summary: List all of the unmet needs to be addressed in the care plan. These needs should correspond to those identified in the Summary Section of the UAI. The reason for the unmet need should be clear from the UAI.

Measurable Objective to Meet Identified Need: A measurable objective is what the client and worker want to achieve for each identified need. These are more specific than the overall goals of case management services. They are written in terms of a client status that is observable or measurable so that the case manager and the client will be able to tell when the outcome has been attained. A common error is listing a service (e.g., home health aide) rather than a client status (e.g., improved functioning as the measurable objective).

Answer the following questions to develop measurable objectives:

1. What is the problem that needs to be solved? For example, you gather the following information from completing the UAI for Mrs. Jones:

Her lower dentures no longer fit; this limits her food intake;
She has lost 10 pounds in 6 months; and she can't afford to have her dentures fixed.

The problem statement that summarizes this information is that Mrs. Jones is losing weight due to the lack of money to repair her dentures.

2. How will I know if the problem has been solved? The answer to this question should be written in terms of a client status that is observable or measurable so that both parties will be able to tell when the outcome has been attained. Some other questions to ask yourself are: Will the client say or do something differently? Will I be able to observe the client doing something differently? Will the client's environment look different?

ASSISTED LIVING FACILITY CASE MANAGEMENT PLAN OF CARE INSTRUCTIONS (con't)

From the example above, the measurable objective is: Mrs. Jones will receive new dentures and report eating solid foods regularly. In writing the objective, focus on short-term changes you will be able to see and which will lead to long-term resolution of the problem. In this example, indicate that you will remove the apparent barrier to Mrs. Jones' ability to eat properly (obtain new dentures), and also say that you will observe her eating solid foods (which will then logically lead to improved nutrition).

Tasks to Be Done to Meet the Objective: In this column, list the tasks to be done to meet each objective. These are the steps taken to solve the problem. Tasks will often involve obtaining a service for the client. For each service, list the provider and the frequency. Informal as well as formal providers should be included. This may be the section you find easiest to complete. If so, you may want to fill out this section first, and then think about the observable or tangible evidence that will be present to show that the task was accomplished. This would be recorded as the measurable objective (column 2).

Expected Time Frame: This is the time frame for accomplishing the measurable objectives.

Date Resolved: Record the date the task was accomplished. If the task was not accomplished, make a note of the reason.

Signatures: There is space for the client and the case manager to sign the care plan. The client signature is an indication that he or she agrees with the plan.

Case Manager Comments: The last section provides space for case manager comments.

ALF Case Management Services Progress Log: Case managers shall maintain a record of case management services provided to the ALF clients. The log shall list the dates of all contacts between the case manager and the direct service providers, the ALF staff, and the client. The log should summarize the nature of those contacts and cover services obtained for the client, how the client is responding, what unmet needs remain, and the progress that is being made toward securing still needed services. The log should also identify any changes in the client's social, environmental, and medical circumstances.

VIRGINIA UNIFORM ASSESSMENT INSTRUMENT ADD-ON PAGE
(for use with the short-form of the UAI--first four pages)

Individual's Name: _____

DIAGNOSES & MEDICATION PROFILE (Page 5 of UAI)

How do you take your medications?

- _____ **Without assistance** ⁰
- _____ **Administered/monitored by lay person** ¹
- _____ **Administered/monitored by professional nursing staff** ²

Describe help: _____

Name of helper: _____

BEHAVIOR PATTERN (Page 8 of UAI)

Does the client ever wander without purpose (trespass, get lost, go into traffic, etc.) Or become agitated and abusive?

- _____ **Appropriate** ⁰
- _____ **Wandering/Passive - Less than weekly** ¹
- _____ **Wandering/Passive - Weekly or more** ²
- _____ **Abusive/Aggressive/Disruptive - Less than weekly** ³
- _____ **Abusive/Aggressive/Disruptive - Weekly or more** ⁴
- _____ **Comatose** ⁵

Type of inappropriate behavior: _____

Source of information: _____

INTERAGENCY CONSENT TO RELEASE CONFIDENTIAL INFORMATION FOR ALCOHOL OR DRUG PATIENTS

I, _____, of _____
(Name of patient/client) (Patient/client's address)

authorize _____ to disclose to:

(Name, title, and organization to whom disclosure is to be made)

the following information: _____
(Specific information to be disclosed)

for the following purpose(s): _____
(Reason for disclosure)

I understand that my records are protected under Federal and State confidentiality laws and regulations and cannot be disclosed without my written consent unless otherwise provided for the laws and regulations. I also understand that I may revoke (or cancel) this consent at any time, except to the extent that action has been taken in reliance on it, and that in any event this consent automatically expires as described below:

(Date, event, or condition upon which this consent will expire)

I further acknowledge that the information to be released as fully explained to me and that this consent is given of my own free will.

Executed this, the _____ day of _____, 20 _____.

This consent ☐ includes ☐ does not include information placed on my records after the above date.

(Signature of patient/client)

(Signature of parent/guardian, where required)

(Signature of person authorized to sign in lieu of parent)

NOTE WHERE INFORMATION ACCOMPANIES THIS DISCLOSURE FORM: This information has been disclosed to you from records protected by Federal Confidentiality of Alcohol or Drug Abuse Patient Records rules (42 CFR Part 2.) The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

CONSENT1

CONSENT2

APPENDIX D

CONTACTS

CONTACTS

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

600 East Broad Street, Suite 1300, Richmond, VA 23219

Long-Term Care Section 804-225-4222
Melissa Fritzman, Program Administration Supervisor 804-225-4222
FAX 804-371-4986

DMAS Provider HELPLINE (have 7-digit provider number ready) 1-800-552-8627
or 786-6273 in Richmond

DMAS Regional Offices

Central Region Community-Based Care Section, DMAS, 600 East Broad Street
Suite 1300, Richmond, VA 23219 804-786-1465

Southwest Region Community-Based Care Section, DMAS, Commonwealth Building,
Suite 330, Roanoke, VA 24011 540-857-7342

Tidewater Area Community-Based Care Section, DMAS, 3 The Koger Center,
Suite 225, Norfolk, VA 23502 757-455-3815

DEPARTMENT OF SOCIAL SERVICES

730 East Broad Street, Richmond, VA 23219

Adult Services Program 804-692-1299
Terry A. Smith, Manager, Adult Services Programs 804-692-1208
Jayne Flowers, Adult Services Programs Consultant 804-692-1263
Cindy Lee, Adult Services Programs Consultant 804-692-1264
Marjorie Marker, Adult Services Programs Consultant 804-692-1262
FAX 804-692-2215

VDSS Regional Adult Services Coordinators

Central Region Barbara Jenkins 804-662-9785
Eastern Region Vacant 757-491-3983
Northern Region David Stasko 540-347-6313
Piedmont Region Bill Parcell 540-857-7448
Western Region Carol McCray 276-676-5636

VDSS Division of Licensing Programs 804-692-1760

VDSS Division of Licensing Programs Regional Staff

Central Region	804-662-9773
Eastern Region	757-473-2116
Peninsula Licensing Office	757-594-7594
Northern Region	540-347-6345
Fairfax Area Licensing Office	703-943-1535
Verona Licensing Office	540-248-9345
Piedmont Region	540-857-7971
Abingdon Licensing Office	276-628-5171

VDSS Division of Temporary Assistance (Benefits) 804-692-1720

DEPARTMENT FOR THE AGING

1600 Forest Avenue, Suite 102, Richmond, VA 23229

Information 804-662-9333 or 1-800-552-3402

DEPARTMENT OF MENTAL HEALTH, MENTAL RETARDATION AND SUBSTANCE ABUSE SERVICES

109 Governor Street, Richmond, VA 23219

Information 804-371-0769

DEPARTMENT OF HEALTH

3600 Centre, Suite 216, 3600 West Broad Street, Richmond, VA 23230

Information 804-367-2100

DEPARTMENT OF REHABILITATIVE SERVICES

8004 Franklin Farms Drive, P.O. Box K300, Richmond, VA 23288

Information 1-800-552-5019

DEPARTMENT OF CORRECTIONS

6900 Atmore Drive, P.O. Box 26963, Richmond, VA 23225

Mr. C. Doug Chaffins 804-674-3047

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